



Credit Repair Authorization & Application Information

NAME(last) _____ (first) _____ (middle) _____
Date Of Birth (month/day/year) _____ SSN# _____
Home Phone _____ Work Phone _____ Cell Phone _____
Home Address _____ Apt / Suite _____
City _____ State _____ Zip _____
E-Mail Address _____ Fax # _____

This agreement is between, _____, hereafter known as client, and East Coast Credit Counselors, Inc. also known hereafter as Coastal Credit Clinic. Coastal Credit Clinic agrees to provide you, the client, the following services upon receipt of signed application and *\$99.00 acquisition fee:

- 1) Order your personal credit reports from the three major credit-reporting agencies, Equifax, Transunion and Experian.
- 2) Provide client with "The Consumer Credit File Rights" Document.
- 3) Provide client with a one on one credit consultation by a credit representative.
(You will be assigned your own Coastal Credit Clinic representative, who will personally handle all communications between yourself and the three major credit bureaus.)
- 4) Process client application and build data file.

In consideration of the above services I also agree to pay \$_____ per month. My agreement with Coastal Credit Clinic can be cancelled without penalty or obligation at any time. **Please be aware that this is a multi-month process. From Experience Coastal Credit Clinic recommends at least six months to get the best results. In the event that your credit profile has been successfully cleared of any and or all obsolete information before the sixth month, you may cancel without penalty.** During the agreement time, Coastal Credit Clinic will: fully assist in the process of removing incorrect, inaccurate, unverifiable information from your credit report that is not in compliance with the Federal Fair Credit Reporting Act. Be advised that once we begin our disputing process you will receive correspondence from the credit bureau, which must forward us all mailings. **(It is the most important part of this process and we must receive everything in a timely manner).**

Although we make no guarantees, Coastal Credit Clinic will diligently work on your behalf to better your credit score with the three major credit bureaus.

Monthly payments are to be made either via credit card, checking account deduction, allotments, money orders and/or bank checks (to be mailed to our office). This is a 6 month agreement, on the 7th month, you the client, will have an option to continue with the program on a month-to-month basis.

I hereby agree that I have read and accepted all terms listed above.

X

Clients signature

Printed name

Date

By law, Coastal Credit Clinic allows you to cancel this contract within three (3) business days from the date you signed the contract.

Please provide the following documentation with this application:

- 1) Legible copy of your driver's license –
must have current mailing address if not, please provide a copy of a utility bill.
- 2) Legible copy of your social security card



Credit Card Authorization

Type of Credit Card: (e.g. Visa, Master Card, American Express etc.)		
Full Name: (as it appears on the credit card)		
Credit Card Number:	Expiration Date:	Security Code on Back
Complete Mailing Address: (address where the statements are sent to)		

Checking Account Authorization

Authorization Agreement For Pre-Arranged Payments

Name of Financial Institution (Bank's Name):
Telephone Number of Bank:
Bank's Routing Number:
Name on Account:
Account Number:
Authorized Signature on Account:

I authorize Coastal Credit Clinic to process payment for fees from the account above. I will notify Coastal Credit Clinic, in writing, of any changes in account information. I further understand that if payment is not received and/or returns NSF or account closed, Coastal Credit Clinic will stop services immediately and there will be a \$30.00 charged to my account for insufficient funds. (Please include copy of voided check)

X

 Clients signature Date



Limited Power of Attorney

I hereby grant a limited power of attorney to Coastal Credit Clinic, and any and all of their staff, who shall have the necessary power and authority to undertake and perform the following on my behalf.

I authorize East Coast Credit Counselors, also known as Coastal Credit Clinic, to obtain my credit report as many times as necessary, prepare, transmit and sign all necessary documents for the purpose of challenging and ascertaining account information of all consumer reporting agencies, but not limited to, credit reporting agencies and creditors.

I also authorize Coastal Credit Clinic, in the event that my payment is not in place at the time of billing to process my payment of \$_____ via credit card or checking account deduction utilizing Pay-Pal and or any processing system that we employ.

X

Clients signature Date

Name of Witness _____

Signature of Witness _____ Date _____

STATE OF _____ COUNTY OF _____

Sworn and subscribed before me the _____(day), of _____ (month)

By _____

Or who was/were personally known to me or who presented as identification:

Notary Public
My Commission expires:



Please Read And Sign This
It Is Required That We Inform You Of Your Rights

You have a right to dispute inaccurate information on your credit report by contacting the credit bureau directly. However, neither you nor any "credit repair" company or credit repair organization has the right to have accurate, current, and verifiable information removed from your credit report. The credit bureau must remove accurate, negative information from your report only if it is over 7 years old. Bankruptcy information can be reported for 10 years. You have the right to obtain a copy of your credit report from a credit bureau. You may be charged a reasonable fee. There is no fee, however, if you have been turned down for credit, employment, insurance, or a rental dwelling because of information on your credit report within the preceding 60 days. The credit bureau must provide someone to help you interpret the information in your credit file. You are entitled to receive a free copy of your credit report if you are unemployed and intend to apply for employment in the next 60 days, if you are a recipient of public welfare assistance, or if you have reason to believe that there is inaccurate information in your credit report due to fraud. You have a right to sue a credit repair organization that violates the Credit Repair Organization Act. This law prohibits deceptive practices by credit repair organizations. You have the right to cancel your contract with any credit repair organization for any reason within 3 business days from the date you signed it. Credit bureaus are required to follow reasonable procedures to ensure that the information they report is accurate. However, mistakes may occur. You may, on your own, notify a credit bureau in writing that you dispute the accuracy of information in your credit file. The credit bureau must then reinvestigate and modify or remove inaccurate or incomplete information. The credit bureau may not charge any fee for this service. Any pertinent information and copies of all documents you have concerning an error should be given to the credit bureau. If the credit bureau's reinvestigation does not resolve the dispute to your satisfaction, you may send a brief statement to the credit bureau, to be kept in your file, explaining why you think the record is inaccurate. The credit bureau must include a summary of your statement about disputed information with any report it issues about you. The Federal Trade Commission regulates credit bureaus and credit repair organizations. For more information contact:

The Public Reference Branch
Federal Trade Commission
Washington, D.C. 20580

Please sign below which shows that you have read and understand the laws regarding credit repair companies and credit bureaus. You must sign and date this and forward a copy to Coastal Credit Clinic for us to legally help you with your credit problems. If joint account both participants must sign and date.

Client Signature: X_____

Date: _____

Client Signature: X_____

Date: _____



AUTHORIZATION AGREEMENT FOR AUTOMATIC WITHDRAWAL OF FUNDS		
East Coast Credit Counselors		ES7401
Customer # (leave blank if not applicable)		
Last Name		First Name
Address		
City		State Zip
<p><u>Please debit payments from my (check one):</u></p> <p><input type="checkbox"/> <u>Checking Account</u> (staple a voided check below)</p> <p><input type="checkbox"/> <u>Savings Account</u> (contact your financial institution for Routing #)</p>		<p>Bank Routing Number:</p> <hr/> <p><u>Valid Routing # must start with 0, 1, 2, or 3</u></p> <p>Account Number:</p> <hr/> <p><small>⋮ 23456789 ⋮ 23 23456 ⋮ 0001</small> Routing Number Account Number Check Number</p>

<p>Date of first payment:</p> <p>_____ / ____ / ____</p> <p>Date of last payment (optional):</p> <p>_____ / ____ / ____</p>	<p>Frequency of payment:</p> <p><input type="checkbox"/> Monthly on the 15th</p> <p><input type="checkbox"/> Monthly on the 30th</p>	<p>Amount of ongoing payment:</p> <p>\$ _____</p> <p>Amount of last payment (optional):</p> <p>\$ _____</p>
---	---	---

AGREEMENT

I authorize the above company and Vanco Services, LLC to process debit entries to my account. I understand that this authority will remain in effect until I provide reasonable notification to terminate the authorization.

Authorized Signature: _____ Date: _____