

CREDIT CARD AUTHORIZATION FORM

Please complete the following information. This form will be securely stored in your clinical file and may be updated upon request at any time.

I, _____, authorize Megan Taylor, LMHCA, to charge my credit card for professional services as follows:

Please Initial:

_____ Recurring charges for services in the amount of \$_____ per visit.

_____ I understand and agree that my card will be charged a fee of \$100.00 for cancellations with less than 24 hours notice and for appointments I miss without notice as agreed to in the Client Consent and Disclosure Form I signed.

_____ I understand this form is valid for one year unless I cancel the authorization in writing. I will not dispute charges ("charge back") for sessions I have received or appointments I missed according to the above policy.

Charges will appear on your credit card statement as "Megan Taylor Counseling Services, LLC."

Visa

MasterCard

Debit Card

Card #: _____

Expiration Date: _____

Name as Printed on Card: _____

Verification/Security Code (the 3---digit code on back of card by signature line): _____

Billing Address (Street, City, State & Zip): _____

Email Address:

Signature

Printed Name

Date