Karoll Counseling, LLC
744 Dulaney Valley Road, Suite 8B, Towson, MD 21204
Phone 443-535-3130 / Fax 410-630-3744

Credit Card Authorization and Consent Form

Patients are required to keep a valid credit card number on file. This credit card will only be used for telehealth sessions, missed appointments, *late cancellations, or delinquent balances (balances more than 60 days past due). This card will not be used for any other reasons than the above stated terms.

Patient Name:

(print):_____

Cardholder's Name:

(print):_____

Card Type (circle one): Visa MasterCard American Express Discover HSA/FSA

Card Number:
_____

Expiration Date: _____/_____ (mm/yy)

3 Digit CVC/Security Code_____

Credit Card Billing Zip Code: _____

I agree that this form is valid for the length of therapy and authorization for the use of this card will be canceled at the termination of therapy. I understand that If my card expires or I want to replace it with another card to keep on file, I will notify Carolyn Karoll, LCSW-C, CEDS-S.

I have read and understand the terms of this credit card authorization form. I authorize Karoll Counseling, LLC to keep my credit card number and my signature on file and to charge my credit card listed above for missed appointments and/or late cancellations at the full rate of session fee, and for any delinquent balances more than 60 days past due.

_____ _____

Cardholder's Signature Date

_____ _____

Carolyn Karoll, LCSW-C, CEDS-S Signature Date

* If you cancel an appointment, please give a minimum of 24 hours advanced notice. If you cancel an appointment without giving 24 hours notice or you do not show, you will be charged for the session with exceptions for inclement weather, illness or emergency. Sessions scheduled on Monday require notice on Friday.