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

I_____, hereby authorize Karoll Counseling, LLC to

charge my credit card for payment of the counseling fees _____

incurs; which shall include late or past due fees or *fees related to cancellations or no-shows.

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 understand as a third-party payor that I am only entitled to receive information concerning payment and that this Credit Card Authorization Form does not authorize me to receive any confidential and protected information beyond payment.

_____ _____
Cardholder's Signature Date

* Late cancellation refers to canceling an appointment with less than 24 hours notice. Full session will be charge unless it is due to inclement weather, an illness or emergency. Sessions scheduled on Monday require notice on Friday.