File # _____
(Internal Use Only)

Universal Counseling, LLC

Authorization to Charge Credit Card for Telehealth Services

The following represents the conditions under which services will be rendered by Universal Counseling, LLC.

CONDITIONS

- _____(Initials) I authorize a charge for Telehealth Services in accordance with signed Fee Agreement.
- _____(Initials) I understand I will be charged either at the time of service or up to a week after services are rendered, due to possible unforeseen restrictions on access to our office at this time.
- _____(Initials) I understand this form will be kept on file.
- _____(Initials) I authorize a late-cancellation charge, in the event that I cancel with less than 24-hour notice, against my credit card for the $25 fee.
- _____(Initials) I authorize a no-show charge, in the event that I do not appear for my scheduled appointment, against my credit card for the $25 fee.

Cardholder Information

Name on Card: _____

Billing Street Address: _____

City: _____ State: _____ Zip code: _____

Phone number: _____

Credit Card Information:

Credit Card Type: ____ MasterCard ____ Visa ____ American Express ____ Discover

Credit Card #: _____

Expiration Date: Month _____ / Year _____ Security Code (# on back of card): _____

Cardholder Signature: _____ Date: _____