**Credit Card Authorization Agreement**

I *(name on card)*, , authorize Donlan Counseling Services to charge my:

Credit Card

Debit Card

*(please highlight or bold/underline your choice)*

The charges include payment for services for the following:

* Services not covered by insurance
* $75 late cancellations *(we require a minimum of 48 hours’ notice)*
* $75 no-show fee
* Overdue co-payments *(normally you will be billed monthly by ABS Billing Services)*

Patient Name:

Name on card:

Billing Address:

Zip code:

Card number:

Expiration date:

CVV:

Card type:

Visa

Mastercard

American Express

Discover

*(please highlight or bold/underline your choice)*

Signature:

Date:

**When completed please email the form back to mdonlan@donlancounseling.com**