Gretchen Burkholder PLLC, LMHC ATR
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Credit Card Authorization Agreement

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

In the case that you miss or fail to cancel an appointment within 24 hours of the scheduled time, or if a check is returned unpaid, you will be charged the full session fee.

I,_____, authorize Gretchen Burkholder, LMHC, ATR to use my credit card information to charge my credit card via PayPal in the event that I do not notify her of my inability to attend schedule therapy appointments and/or do not cancel my appointment at least 24 hours in advance, or if a check is returned for any reason. I will not dispute charges ("charge back") for sessions I have received or appointments I have missed according to the above policy.

Card Type (circle one): VISA MasterCard Discover American Express

Card #:_____ Expiration Date: _____

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

Name as Printed on Card: _____

Billing Address: _____

City:_____State:_____Zip:_____

Phone:_____Email: _____

By signing below I am authorizing Gretchen Burkholder to charge for missed scheduled

appointments.

Signature:_____Date: _____