Payment for Services Authorization Form

I, _____ (print name) give my consent to Melissa Robilliard, M.S., LPC to charge the card listed below to collect copayments for counseling sessions. I also give consent for this card to be charged $140.00 for any session that is cancelled or missed with less than 24-hour notice, related to the treatment of:

Client Name: _____

Client Date of Birth: _____

Card Information

Name on Card: _____

Card Number: _____

Expiration Date: _____ CVV: _____

Authorization

Signature: _____

Date: _____

Melissa Robilliard LPC
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