

# Veronica Gulezian MA, LCPC, CADC

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## Credit Card Authorization

In order for me to accept and bill your credit card, please complete all fields below, then sign and date. All information kept on file is confidential.

### Contact/Billing Information

Client Name: \_\_\_\_\_

Cardholder Name (if different from client:) \_\_\_\_\_

Credit Card Billing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Cardholder Phone: \_\_\_\_\_ Please check one: ☐ Cell ☐ Home ☐ Work

Credit Card Type: \_\_\_\_\_

Credit Card # \_\_\_\_\_

Exp. Date (mm/yyyy): \_\_\_\_\_ Credit Card Security code: \_\_\_\_\_

**Please note:** I process credit card payment for any balance due as soon as possible, but no later than 60 days after services have been provided. This includes any session fees (for out-of-pocket clients), copays, cancellation fees, phone call fees, and sessions not paid for by insurance if a client is using insurance (please see "Appointments, Fees, and Cancellations" in the Welcome Letter). If a parent or other responsible party is paying for sessions, I can ONLY communicate with that party about payment, not about session content. Session confidentiality can only be broken under HIPAA guidelines or with written permission from the client. If a party other than the client is paying for sessions, I will ask the client to sign a Release of Information at the first session allowing me to communicate with that party regarding payment ONLY.

**By signing below, I understand all the information above and authorize Veronica Gulezian, LCPC, CADC to charge my credit card for counseling services. I will not dispute the any changes made that abide by the outlined policies.**

Client Signature: \_\_\_\_\_

Print Client Name: \_\_\_\_\_ Date: \_\_\_\_\_

Cardholder Signature (if different than client): \_\_\_\_\_

Print Cardholder Name: \_\_\_\_\_ Date: \_\_\_\_\_

*Thank you for your business!*