Karma Counseling
Zahra Payravian, LPC

Karma Counseling LLC

CREDIT CARD AUTHORIZATION

NO SHOW/LATE CANCELLATION FEES, INSURANCE COPAYS & DEDUCTIBLES, THERAPY FEES

In order to provide you and other patients of, *Zahra Payravian, LPC;* the best possible care, a minimum of 24 hours notice is required to cancel or reschedule your appointments.

I, _____, understand the importance of notifying my *therapist* at least 24 hours prior to my scheduled appointment that I am not able to keep my appointment. If I am experiencing an emergency, I will provide as much notice as possible to avoid being charged the Late Cancellation fee of $50. I understand that I will be charged a No-Show fee of $75 for failing to call and failing to show for my scheduled appointment.

I, _____, give *Zahra Payravian, LPC* the authorization to charge my credit card $50 for each missed therapy session where 24 hours notice is not given and $75 for each missed therapy session where I fail to call and show for the appointment. This credit card will also be used for all fees that have not been paid within 60 days (unless other arrangements for payment have been agreed upon in writing between me and my therapist). I will be provided a receipt for all payments upon request. This card may also be used for payment of services upon my request (co-payment, deductibles, and fees).

I understand that I may revoke this agreement at any time by providing a request in writing. I am also aware that when psychotherapy services rendered by *Zahra Payravian, LPC* have ended, this form shall be shredded once I am terminated from treatment.

I am requesting that this card be used for payment of services (co-pay & fees): ____ Yes ____ No

Name on card: _____

Card Number: _____ - _____ - _____ - _____

Expiration Date: _____ / _____

Code: _____ Street Address: _____ Zip Code: _____

Email address for receipt: _____

Patient Name (printed): _____

Patient (or Parent/Guardian)/Card Holder Signature:

_____ Date: _____