

Atlanta Couple Therapy,
A Gifted Counseling LLC Company.
303 Perimeter Center North Suite 300
Atlanta, GA 30339
(404) 496-8070 (office)
www.AtlantaCoupleTherapy.com



Credit Card Authorization Form

Please note that this form will be securely stored in your clinical file and that you are willing to assume the risk for keeping this information on file.

I authorize Dr. Laura Louis, Ph.D. Licensed Psychologist doing business as Gifted Counseling LLC to keep my signature and card information on file and to charge therapy session fees (individual, group, workshops, couples, family or other), and any fees related to therapy related materials (workbooks, DVD's, CD's, and other materials, and or fees), or for any appointments with Dr. Laura Louis, Ph.D. Licensed Psychologist that are not cancelled 48 hours before the scheduled appointment time to be charged to my credit, charge, or debit card or flex spending account as filled out below for therapy services provided to:

(Therapy Client's Name: Please Print)

I understand that this authorization is valid until canceled in writing. I understand that though this information is secured in my client file, and is unlikely to be tampered with, I agree to assume the risk if the file and credit card information is compromised. I understand that charges for on-going services or materials will normally be posted to my credit/debit/flex card account within 48 hours of each session date and **my session fee will be charged at the start of the day on the day of my session.** Additionally, I agree that the card listed below may be charged by Dr. Laura Louis, Ph.D. Licensed Psychologist doing business at Gifted Counseling LLC in order to settle any outstanding balances accrued by the above listed client upon termination of therapy services including any materials [i.e. books, CD's, DVD's] that I have not returned within one week of termination. I understand that if a charge back fee is incurred or a retrieval fee of is incurred I am responsible for these fees. Initial _____

I agree that if I have any concerns or questions regarding charges to my account, or if the charge fails to post to my account, I will contact Dr. Laura Louis, Ph.D. Licensed Psychologist for assistance and/or disclosure. I agree that I will not dispute any charges with my credit card company unless I have already attempted to rectify the situation directly with Dr. Laura Louis, Ph.D. Licensed Psychologist and those attempts have failed. Initial _____

Further, if I am assuming session payment responsibility for the client above whose name is listed in the printed area, and that client is someone other than myself, I understand that I am not entitled to information pertaining to confidential therapy sessions as provided by Dr. Laura Louis, Ph.D. Licensed Psychologist Initial _____

I understand and agree to these terms. I understand the conditions of this payment policy and agree to the conditions stated above:

Cardholder Name [print]: _____

Signature _____

Relationship to client: _____

Billing Address: _____

Zip Code: _____

Card Type (**circle one**): 1. Visa 2. Mastercard [Note: I do not accept AMEX]

Acct. Number: _____ - _____ - _____ - _____

Exp. Date: _____ 3 digit Security Code _____

I understand that my therapy sessions will be charged via this form and not by swiping my card on the morning of my session unless cancelled 48 hours in advance:

Cardholder Signature: _____