**Eddie P. Millhollon, Ph.D., LPC-S**
**Caledonia Family Counseling LLC**

*Credit Card on File Authorization*

I, _____, authorize Eddie P. Millhollon, Ph.D., LPC-S at Caledonia Family Counseling LLC to charge my credit card for psychotherapy sessions at the initial session rate of $200.00 and subsequent session rate of $175.00 or at the contract rate in accordance with my insurance plan. In addition, I authorize Eddie P. Millhollon, Ph.D., LPC-S at Caledonia Family Counseling LLC to charge my credit card for cancellation or rescheduling of sessions not honoring the 24-hour cancellation policy as well as missed sessions at the full rate which is an out-of-pocket cost. Missed/canceled sessions cannot be billed to insurance. I guarantee pay for any services rendered made with my credit card, including renewed cards.

_____ _____
Authorized Signature of Cardholder Date

_____
Printed Name of Cardholder

Card Type:
- ☐ American Express
- ☐ Visa
- ☐ Mastercard
- ☐ Discover

Card Number: _____
Expiration Date: _____
Security Code: _____
Name as it appears on credit card: _____
Billing Address: _____
Street Address

_____ _____ _____
City State Zip