Dr. Roberta L. Marowitz, LMFT

COUNSELING & RELATIONSHIP INSTITUTE
237 Lookout Place, Maitland, FL 32751
Phone: (407) 865-3855 Fax: (321) 203-2512

Credit Card on File Authorization Form

I authorize Counseling & Relationship Institute to keep my signature on file and charge my credit card account for:

- Charges for services rendered
- Charges for missed appointments (including those not canceled within 48 hours)
- Balances of charges not paid by me within 30 days
- An administrative $5.00 fee will be charged

I understand that I may revoke this agreement at any time by providing a request in writing.

Client Name: _____

Cardholder's Name: _____

Cardholder's Address: _____

City: _____ State:_____ Zip:_____

- ▢ VISA
- ▢ Master Card
- ▢ Discover
- ▢ American Express

Account Number: _____

Expiration Date: _____/_____ CVV#: _____

_____ _____/_____/_____
Signature of Client Date

_____ _____/_____/_____
Signature of Legal Guardian, if needed Date