

NEW DAY COUNSELING, LLC
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CREDIT CARD AGREEMENT

Please complete your credit card information below. By providing this information it will simplify payment procedures in the event of a missed appointment without cancellation, as well as the occasions where an appointment is cancelled without 24 hours notice. By signing this agreement, your account will always be current.

Type of Card:



Visa



Master Card



Discover Card

Card Number: _____

Expiration Date: ____/____ (MM/YYYY)

Security number on Card: _____ (3 digits on back of card)

Name on Card: _____(please print clearly)

Address of Billing Address for Card:

Full Street Address or P.O. Box

City

State

Zip Code

Phone Number: _____

By signing below, I authorize Perette M. Halpin, LCSW-C or New Day Counseling, LLC, to charge my credit card for services rendered or for late cancellation/missed appointment fees:

Signature

Date