Client _____

Therapist _____

**Metropolitan Counseling Associates, LLC**
7201 Wisconsin Ave., Suite 700
Bethesda, MD 20814
301-654-7770
Tax ID #20-2833850

## Authorization for Credit Card Use

**Metropolitan Counseling Associates requires a credit card on file for all clients**.

**Please read, sign and date below:**

I authorize Metropolitan Counseling Associates, LLC to use the credit card information that I have provided below to manually charge my credit card for mental health services provided through Metropolitan Counseling Associates, LLC to me and/or my child. I understand and accept that my credit card will be charged at the completion of any services rendered.

_____ _____
Signature Date

**Please provide all of the information requested below:**

_____ Visa MC AmEx
Credit card number (circle one)

_____ _____ _____
Cardholders name as it appears on card Expiration date Card Code

_____
Cardholders billing address with zip code