Credit / Debit Card Payment Consent Form

Name: _____

Name on Card if different than client: _____

Credit/Debit/ Health Account #: _____

Expiration: _____

Security Code: _____

I authorize Empowered Wellness Counseling, LLC to charge my credit/debit/health account card for professional services after our scheduled appointment. If I do not cancel before 24 hours, I recognize that _____ will charge my card for the appointment. I will be billed my co-pay.

I verify that my credit card information, provided above, is accurate to the best of my knowledge. If this information is incorrect or fraudulent or if my payment is declined, I understand that I am responsible for the entire amount owed and any interest or additional costs incurred if denied. I also understand by signing and initialing this form that if no payment has been made by me, my balance will go to collections if another alternative payment is not made within thirty days.

I understand that this information will be held in a secure HIPAA compliant electronic health record system and I will have access to a copy of this signed form.

Signature: _____
Date: _____