a l e t h e a t h o m a s

C O U N S E L I N G

Credit / Debit Card Payment Consent

Printed Client Name:_____ Date:_____

Name on card if different than client (Card Holder):

_____ Card Type:_____

Card number:_____ Expiration Date:_____ CVV: _____

Mailing address with zip code:_____

I authorize Alethea Thomas Counseling to charge my credit/debit/health account card for professional services 24 hours before our scheduled appointment.

If I do not cancel before 24 hours, I recognize that Alethea Thomas will charge my card as a late cancel or no show if I do not show up for the appointment. I will be billed for $75 for each session missed.

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 or my insurance company, my balance will go to collections if another alternative payment is not made within thirty days.

Please note, Alethea Thomas Counseling will add a convenience fee for all credit card charges.

Client Signature: _____

Card Holder Initials (If different than client): _____