INTEGRATIVE PSYCHOTHERAPY AND ASSESSMENT SERVICES, PLLC

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Credit Card Payment Consent Form

Client Name_____

Name on card if Different:_____

I authorize Integrative Psycho-Therapy and Assessment Services to charge my credit card for professional services as follows:

Initials:

_____All visits in the next 12 months (session fee is $150.00)

_____Document preparation (hourly fee of $150.00)

_____No show or late cancelation fee is the session fee of $150.00. This policy is strictly enforced.

_____Charge my card for the balance not paid by my insurance company within 90 days.

Type of Card: Visa/Mastercard/Discover/American Express

Card Number _____-_____-_____-_____

CVV Number_____

Expiration Date___-___-___

Card Holder's billing address for credit card statements:

_____

Street City State Zip

Card Holder Signature:_____

Date:_____