REFLECTIVE
COUNSELING

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CREDIT / DEBIT CARD PAYMENT CONSENT FORM

Client Name: _____

Name on Card if different than Client: _____

I authorize Reflective Counseling to charge my credit/debit/health account card for professional services the day of our scheduled appointment.

I verify that my credit card information provided to Reflective Counseling 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 60 days.

Client/Payee Signature: _____

Initials: _____ Date: _____