Wise Mind Psychological Services P.L.L.C.

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1800 Gormley Ave
Merrick NY 11566-0001
646-423-9543

13. Credit / Debit Card Payment Consent for (Wise Mind Psychological Services)

Client name:

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

Card Type:

Card Number:

CVV Number:

Card Expiration Date:

I authorize Wise Mind Psychological Services to charge my credit/debit/HSA or FSA card for professional services rendered. If I do not cancel my session 24 hours prior to its scheduled time, I recognize that Wise Mind Psychological Services will charge my card $65 as a late cancellation or no show fee, if I do not show up for the appointment.

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.

Client Initials:

Card holder Initials (If different than client):

Date:

Signature: