Better Mental Health Services
1684 E. Gude Dr, Suite 102
Rockville, MD 20850
(202) 779-3916

Credit Card Payment Consent

Client's Name: _____

Card Holder's Name: _____

Card Number: _____

Expiration: _____ CVV: _____ Zip code: _____

I authorize Better Mental Health Services to charge my credit/debit/health account card for all services, fees (to include credit card fees at a rate of 4%), and appointments. If I do not cancel my appointment before 24 hours, I understand that Better Mental Health Services will charge my card $100 as a late cancel/no show 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.

Signature: _____

Date: _____