**RESTORATION COUNSELING CENTER**

**PAYMENT & CANCELLATION/RESCHEDULE POLICY**

I understand that it is the policy of Christine Holliday MA, LMHC (Restoration Counseling Center) that the client or the parent/guardian of clients under 18 years of age is responsible for payment at the time services are rendered.

· I understand that payment (cash, check, or debit/credit card) for sessions will be conducted the same day, immediately following the scheduled counseling session.

· I will be responsible for a payment of **the full session fee** for failure to attend my scheduled appointment and/or reschedule within a minimum of **24 hours** prior to my scheduled appointment. Emergency circumstances may be given special consideration by the therapist.

· In cases of bank-refused payment (i.e. overdrafted funds), I understand that my credit card will be charged for the original session fee plus any additional fees incurred resulting from the overdrawn charge (i.e. bounced checks).

· If payments are not current, all future sessions will be postponed until the client’s account is paid in full.

· I understand that I am responsible to notify Christine Holliday MA, LMHC if my credit card information changes.

· If for any reason a current credit card is not on file to be charged the aforementioned fees, Restoration Counseling Center may bill me directly.

*I agree that Christine Holliday MA, LMHC may charge payment to the following credit card with the information below for unattended appointments, delinquent rescheduling, and/or bad charges.*

**Credit/Debit Card Information:**  r **Visa** r **Mastercard** r **Discover** r **Other: \_\_\_\_\_\_\_\_**

**CC# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name (As Appears on Card): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CVV #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Billing Zip Code For Card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Client/Guardian Name (please print):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Client/Guardian Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_