



Take your life to the next level

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Credit/Debit Card Payment Consent Form

Client Name: _____

Name on Card if different than client: _____

Card Number: _____

3 digit code on back_____ **Expiration Date:**_____

Billing Zip Code:_____ **House Number #**_____

I authorize HKB Consulting, LLC/DBA IE Counseling to charge my credit/debit/health account card for professional services 24 hours before our scheduled appointment. If I do not cancel before 24 hours, I recognize that Heidi Kiebler-Brogan will charge my card as a late cancel or no show if I do not show up for the appointment. I will be billed for the full session charge:

\$300 per hour for initial consult and assessment (or prorated calculations of this, depending on the length of meeting)

\$275 per hour, for individual sessions (or prorated calculations of this, depending on the length of meeting)

\$225 per 45 mins, for individual child sessions (or prorated calculations of this, depending on the length of meeting)

\$300 per hour for parent/professional consults, family and couples' sessions (or prorated calculations of this, depending on the length of meeting)

The designated per hour rate will be charged for case management/documentation, phone etc. (or prorated calculations of this, depending on the length of service)

I/We authorize HKB Consulting, LLC/DBA IE Counseling to charge my credit card for professional services for our scheduled appointments. I/We recognize that PayPal/Venmo (if elected choice of payment) is not a HIPAA protected payment site but authorize its use for payment anyway. I/We will not hold HKB Consulting, LLC/DBA IE Counseling responsible for any HIPAA privacy violations in conjunctions with my choice to pay by credit card or balance via PayPal/Venmo processing as my form of payment.

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.

Full Name: _____

Signature: _____ Date: _____

Initials: _____