Empowering Relief Counseling, PLLC
*Affirm * Connect * Empower*

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Credit/Debit Card Payment Consent Form

Client Name: _____

Card Holder Name (if different from client name): _____

Card Type:

☐ Visa ☐ Master Card ☐ Discover ☐ American Express

Debit Card: ☐ **Health Savings Account:** ☐

Last 4 Digits of Card Number: _____

Expiration Date: _____/_____

I authorize Empowering Relief Counseling, PLLC (ERC) to charge my credit/debit/health account card for professional services within 24 hours of our scheduled appointment. If I do not cancel before 24 hours, I recognize that ERC 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 per ERC's Fee Schedule.

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 this form that if no payment has been made by me, my balance may go to collections if another alternative payment is not made within thirty days.

Signature: _____ **Date:** _____