FOOTHILLS
COUNSELING AND WELLNESS CENTER

Credit / Debit Card Payment Consent Form

Client Name: _____

I, _____, authorize Foothills Counseling and Wellness Center to store a credit/debit/health account card on file.

I verify that my credit card information, as provided to my counselor, 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.

Card number: _____ Expiration Date: _____

Cardholder name:_____ Security Code (CVV): _____

Card type (Visa, MasterCard, American Express): _____

Billing address: _____

I authorize Foothills Counseling and Wellness Center to charge the credit/debit/health account card I've provided for professional services if I do not cancel at least 24 hours before my scheduled appointment. I recognize that Foothills Counseling and Wellness Center 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.

_____ _____
Name: Individual or Legal Representative Date

_____ _____
Signature: Individual or Legal Representative Date