

Lara Neely, DBH, MED, LPC

CREDIT/DEBIT CARD PAYMENT CONSENT FORM

Client name (Last, First, Middle):

Cardholder name on card if different than client (Last, First, Middle):

Card Type:

Zip Code:

Credit Card Number:

Expiration Date:

CVV Code:

I authorize Lara Neely, DBH, MED, LPC to charge my credit/debit/health account card for professional services immediately following our scheduled appointment. If I do not cancel before 24 hours, I recognize that my card might be charged as a late cancel or no show if I do not show up for the appointment (pursuant to the Cancellation Policy).

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 90 days.

Date:

Signature of Cardholder:

Signature of Client: