PsychSolutions4WV

Credit / Debit Card Payment Information & Consent form

Client name:

(Card holder) Name on card if different than client:

Cardholder's Address:

Billing Zipcode:

Card Type:

Card Number:

CVV (on back of card):

Expiration Date:

I authorize PsychSolutions4WV to charge my credit/debit/health account card for professional services 24 hours before our scheduled visit. Cancellations are not permitted within 24 hours of the scheduled visit.

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.

Client Initials:

Card holder Initials (If different than client):

Date:

Signature: