INNERSIGHT
LLC
PRIVATE PRACTICE MENTAL HEALTH COUNSELING

Credit / Debit Card Payment Consent Form

Client Name: _____

I authorize Innersight LLC or my assigned therapist 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 Innersight LLC will charge my card as a late cancel or no show if I do not show up for the appointment. I will be billed 75.00 dollars for the missed service. My therapist has the right to wave this if within reason.

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.

I approve my card be charged for late cancel or no show, co pays, unmet deductible or coinsurance if needed.

Signature: _____

Name on Card:_____
Type of Card:_____
Number on Card:_____
Exp Date:_____
CVC:_____
Billing Zip Code_____

CoPay: _____
Charge if deductible is not met (yes or no)_____
Self Pay Charge:_____