CREDIT CARD CONSENT FORM

CLIENT NAME _____

NAME ON CARD IF DIFFERENT _____

Turning Leaf Therapy is a small private practice and in order to keep costs down, and to ensure timely payment for services provided, we ask that you provide us with a credit/debit card to put on file for any balances on your account. By signing this form, you are authorizing Turning Leaf Therapy to charge this card for professional services as follows:

- Full session rate for late cancellation (less than 24 hr notice) and no-show fees
- Any co-pays, deductibles, co-insurance, or spend-down amounts due
- Any remaining balances after insurance is billed (please note not all plans have a balance after insurance is billed)
- The entire session fee if no insurance policy is being billed

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me
- That I fully understand its contents
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

BY SIGNING BELOW, I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Card holder signature _____ **Date** _____

CREDIT CARD NUMBER _____

CSC (3 or 4 digit security code on card) _____

EXPIRATION DATE _____Billing Zip Code_____