Pamela Gates MA, LPC, LCDC

Payment Consent Form

Name on Card_____

Type of Card: Visa Mastercard HSA Discover

Email address: _____

Card Number: _____- _____-_____-_____

Expiration date: _____ Security Code _____

Card Holder's billing Address for Monthly Card Statements:

_____

Street/ PO Box City/State Zip Code

I authorize Pamela Gates to charge my credit card for professional services as follows:

____ Initial visit in the amount of _____

____ Session charges in the amount of_____

____ NO SHOW RATE: $60.00 for first event, Full fee of _____ for subsequent events.

____ Late Cancellation (less than 24 hrs notice) No fee for verified illness or injury. Copay or 50% of session rate. Expected fee per late cancel: _____. Full fee of _____ if there is a pattern of late cancellations.

Please be aware that unless an agreement is negotiated with the above provider all outstanding balances not paid within 30 days, after a bill is sent or the insurance company has notified you or this office of your balance, will be charged to your credit card.

_____

Cardholder's Signature Date

Please note that all information will be kept confidential and that the information will only be used to obtain payment for services.