



## Renewed Heart Counseling, LLC

### Credit / Debit Card Payment Consent

Client name:

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

Card Type:

Last 4 digits of card number:

Expiration Date:

I authorize Renewed Heart Counseling, LLC to keep my credit card on file and to charge my credit/debit/health account card for professional services. I have read and understand the 48 hour cancellation policy detailed in the Psychotherapy Agreement. If I do not cancel before 48 hours, I recognize that Kathleen Kozlowski, MS, LPC, NCC will charge my card as a late cancel or no show if I do not show up for the appointment. For that circumstance, I will be billed the full session charge of \$135.

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: