Art of Therapy Center
A holistic approach to therapy with families.

# Credit/Debit Card Payment Consent Form

**Client Name: _____Date of Birth:_____**

**Name on Card if different than client: _____**

I authorize Art of Therapy Center 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 Art of Therapy Center will charge my card as a late cancel or no show if I do not show up for the appointment. I will be billed for the full session charge (breakdown charges per service).

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.

Signature:_____
Initials: _____
Date: _____

## Credit Card Information

Type of Credit Card:
☐ Visa ☐ American Express ☐ Discover ☐ MasterCard

Number on the Card: _____
Expiration Date: _____
CVV:_____