



Willow Creek Counseling Center, LLC

859-554-0740

1050 Chinoe Rd. Suite 203 Lexington, KY 40502

Credit / Debit Card Payment Consent Form

Client Name: _____ Name on Card: _____

Billing Address: _____

Card Type: _____ Card Number: _____

CCV: _____ Expiration Date: _____

I authorize Willow Creek Counseling, LLC 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 Willow Creek Counseling, LLC will charge my card as a late cancellation or no show if I do not show up for the appointment. I will be billed for the full session charge.

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 sixty days.

Signature:

Initials: _____ Date: _____