PAYMENT CONSENT

Client Name ____

I agree to be responsible for full payment of my bill due to Ebtide Counseling LLC. I understand that Ebtide Counseling LLC prefers to receive payment in the form of cash. I also understand that Ebtide Counseling LLC may charge my credit card for any unpaid or overdue balances. I agree to provide a current, valid credit card for this purpose. I understand that charges may appear on my credit card statement as Professional Charges, Square, or Ebtide Counseling LLC. I authorize Ebtide Counseling LLC to charge my credit/debit card for professional services as follows:

Please Initial

_______ This visit only, for the amount of $__________

_______ All visits in the next 12 months, beginning _____________

_______ Recurring charges, date(s) of service ____________

- ☐ Weekly
- ☐ Biweekly
- ☐ Monthly

_______ To charge my card for the balance of fees not paid by my insurance company (required) within 90 days.

Type of Card:

______Visa _____ Master Card ______Discover _____ AmEx ____ Medical Flex/Savings

Name as it appears on Card ____

Card Holder's Address ____

Credit Card Number ______________________________CVV Number ______________

________ I understand that I will be charged a fee for all stopped payments, charge backs, and disputes initiated over funds owed to Ebtide Counseling.

Card Holder Signature: __________________________________Date: _________________