**Credit Card Consent Form**

**We require a 24-hr cancellation notice as a courtesy to other clients wanting to be seen and to our Therapist**

Our practice requires all patients have a credit card on file for **missed appointments and outstanding balances** that are not paid for after verbal or billing statement notice. Please fill this document out completely, you will not be seen without doing so.

**How we handle your credit card information:** once this sheet filled out we scan it into a secure file that is stored in a secure cloud after which we shred this page.

* No-show $40.00
* Cancellation without 24-hour notice $40.00

**Information to be completed by the card holder:**

Card Type: \_\_\_ Visa. \_\_\_ Master Card. \_\_\_Discover

Cardholders Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Card Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Valid until Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_. Security Code: \_\_\_\_\_\_\_\_\_\_ ( 3 digit code on the back)

Billing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. State: \_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ACKNOWLEDGEMENT**

I hereby authorize **World of Hope Counseling Center** to charge my credit card on file for any missed appointments and/or late cancellation. I also authorize **World of Hope Counseling Center** to charge my credit card in the event I have an outstanding balance not payed for a month after notification that I have an outstanding balance either verbally or through a billing statement.

The above information is completed and correct to the best of my knowledge. I agree to update any information pertaining to this account. I understand that **World of Hope Counseling Center** will do everything in their power to protect my personal information and will not be held responsible for any breaches for any breaches that could accrue.

**Cardholder Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**