

Credit Card Payment Consent Form

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name on credit card if different than client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Credit card number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CV: \_\_\_\_\_\_ Street #:\_\_\_\_\_\_\_

Zip code: \_\_\_\_\_\_\_\_

I authorize Still Emerging, LLC to charge my credit/debit/health account card for missed appointments without 24 hrs. notice given, returned payment, or incomplete payment for professional services. I recognize that Carrie Powell will charge my card if the appointment is canceled without 24 hrs. notice (exceptions include cases of emergency or unforeseen life circumstances) or if I do not show up for the appointment. I will be billed for the full session charge of \_\_\_\_\_\_\_, the agreed sliding scale fee.

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 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.

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| --- | --- | --- |
| Signature | Initials | Date |