ReFocus Together
Counseling Services

Credit/Debit Card Payment Consent Form

Client Name: ____

Name on Card if different than client:____

Card Number ____

Expiration Date____

Security Code: ____

I authorize REFOCUS TOGETHER to charge my credit/debit for professional services 24 hours before our scheduled appointment. If I do not cancel before 24 hours, I recognize that REFOCUS TOGETHER 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.

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 (30) days.

____ ____________________

Client/Guardian Signature Date