Beyond Healing Counseling and Wellness

14933 S Founders Xing
Homer Glen IL 60491-6712
7087377968

0. Credit /Debit Card Payment Consent

Client name:

(Card holder) Name on card if different than client:

Card Type:

Card number:

Expiration Date:

CVV:

I authorize Beyond Healing Counseling and Wellness to charge my credit/debit/health account card for professional services. If I do not cancel before 24 hours, I recognize that Beyond Healing 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 late cancel/no show of $75.00.

Client Initials:

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 thirty days.

Client Initials:

I authorize Beyond Healing to keep my signature and credit card information on file and to charge my account for balances that remain unpaid including coinsurance/copays/deductibles/unpaid balances from insurance upon the office of Beyond Healing receipt of your insurance’s Explanation of Benefits. I understand that this authorization will remain into effect until I cancel it in writing, and I agree to notify Beyond Healing in writing of any changes in my account information or termination of this authorization.

Client initials:

Card holder Initials (If different than client):

Date:

Signature: