OceanHawk Counseling Alternatives llc
3185 DEER POINT DRIVE, STE A
STOUGHTON WI 53589-3773
608-873-7838

# 9. Credit / Debit Card Payment Consent 2021

Client name:

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

Card Type:

16 Digit card number:

Expiration Date :

3 Digit security code:

I authorize OceanHawk Counseling Alt. to charge my credit/debit/health account card for professional services at the end of each week following my appointment. If I do not cancel before 48 hours, I recognize that my therapist will charge my card as a late cancel or no show if I do not show up for the appointment of $50.

☐ Deductible

Amount of each Session until Deductible is met:

☐ Co Pay

Amount of Co Pay:

☐ Payment Plan (add'l to any above amounts)

Amount of Weekly payment:

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:

Card holder Initials (If different than client):

Date:

Signature: