Credit Card on File

Illuminate Counseling

Kimberly McMartin, LMHC

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of Card (Circle One): Visa MasterCard American Express Discover HSA

Name on Card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Security Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Credit Card #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Exp Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address Associated with Card:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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I authorize the above named therapist to run my credit card listed above for co-pays and/or co-insurance fees. The credit card will also be used to process a cancellation fee of $50 in the event that a client cancels with less than 24 hours notice. If you would like to change your credit card on file, please inform therapist of this choice and allow up to 2 business days for this change to take effect.

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Patient or Guardian Signature Date

**Termination of Card on File**

I am requesting that my credit card on file be removed effective: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ my card will no longer be used by the Provider listed above and I will be responsible for remitting payment in full when my bill is received. Failure to remit payment in full within 90 days may result in my account being turned over for collections.

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Patient or Guardian Signature Date