Credit Card Consent Form

Patient name:

Name on Card:

I authorize West Counseling, PLLC., to charge my credit card for professional services including but not limited to: Clinical services, Psychological Services, Psychiatric services. telepsychiatry sessions / phone calls (with patient or in regard to patient), emails, missed appointments, form preparation, or other requested service. Client will be charged for copay/Client Responsibility, Missed appointments will be automatically billed for $50.00 if the appointment is not cancelled one business day prior to scheduled appointment. \_\_\_\_\_ Initials

Type of Card:

Card Number:

CVV Number:

Expiration Date:

Billing Zip Code:

Email for receipts:

Card Holder Signature: Date: