

***Pathway To H.O.M.E Counseling and Wellness Services,  
LLC.***

**Credit / Debit Card Payment Consent Form**

**Client Name:** \_\_\_\_\_

**Name on Card if different than client:** \_\_\_\_\_

Card Number and Expiration Date: \_\_\_\_\_

Four digit code on back of card: \_\_\_\_\_

I authorize Pathway to HOME Counseling and Wellness Services, LLC. to charge my credit/debit/health account card for professional services rendered before or immediately after our scheduled appointment. If I do not cancel before 24 hours, I recognize that PHCWS 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 (breakdown charges per service).

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.

Signature: \_\_\_\_\_

Initials: \_\_\_\_\_

Date: \_\_\_\_\_