



#### **4. Credit / Debit Card Payment Consent (1)**

Client name:

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

Card Type:

Last 4 digits of card number:

Expiration Date:

I authorize Bee Lyne Mental Health LLC to charge my credit/debit/health account card for professional services after our scheduled appointment. If I do not cancel before 8 am the day of service, I recognize that Deborah Lyne LLC 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.

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 if at a future date that I dispute a credit card charge Bee Lyne Mental Health will provide information to the credit card processing company with the proof of the validity of the charge. 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: