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# Credit/Debit Card Payment Consent Form

**Your Name** _____
*Print Last* *First* *Middle Initial*

**Client Name** (if different) _____

**Type of Card:** ☐ VISA ☐ MasterCard ☐ Discover ☐ American Express

**Card Number** _____ _____ _____ _____ **CVV Number** _____

**Exp. Date** _____ **Is This Card a Health Savings Account?** YES NO
(MM/YY)

Card Holder's Billing Address

_____
*Street* *City* *State* *Zip*

* All clients of LeNaya Smith, Kaleidoscope Therapy Consultations are required to have a credit card on file.

**Must initial below:**
_____ *I understand that if I fail to give a 24 hours' notice for cancelled appointments, I*
*(Initial)* *will be charged for the time which has been reserved for me.*

**Please choose one of the following:**

_____ *Please charge this card for sessions.*
*(Initial)*

_____ *I plan to pay by cash or check and understand that this card will only be charged*

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*(Initial)* *if I do not make a payment at the time of service, for missed appointments, or if I cancel without giving appropriate notice.*

**Signature** _____ Date ____ /____ /_____