Credit / Debit Card Payment Consent Form

Client Name: _____

Name on Card if different than client: _____

Credit Card number/exp. Date/code:

Zip code:_____

I authorize Dr. Stefanie Rosen to charge my credit/debit/health account card for professional services if I do not cancel before 48 hours. I recognize that Dr. Stefanie Rosen 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 of $ _____.
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: _____