PAYMENT AGREEMENT

If using HSA, FSA, or Credit Card for payment

Name on Credit Card____

Card Number____

Expiration Date_______________Security code__________Billing Zip ___________________

Email for send of Receipt ____

By signing this form, I authorize DK Counseling and Clinical Supervision LLC to charge the above credit card for services or fees related to any of the following: therapeutic services, assessment, consultation, therapeutic sessions (individual, couples, group, EMDR, etc.), clinical supervision, no-show/late cancelations, legal services and any unpaid balances.

Printed name and signature of person authorizing the use of credit card: Date:

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