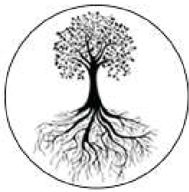

Denise J. Hockley MS, LMFT
OR License # T1513 CA License # LMFT30255

LICENSED MARRIAGE
& FAMILY THERAPIST

PHONE: 760-822-7729
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Credit/Debit Card Payment Consent Form

Client Name ____

Print Last ***First*** ***Middle Initial***

Phone: _________________________ Email address____________________________

Name on Card if different ____

Card Holder's Billing Address for Credit Card Statements:

____

Street City State Zip

☐ Visa ☐ MasterCard ☐ American Express ☐ Discover ☐ HSA/FSA

Acct. # ____

CSC# __________ (3-digit # on back of card) Exp. Date: ____________________________

I authorize the use of my credit/debit card as described below for charges related to services provided by Denise Hockley, LMFT, including:

☐ Payment for my sessions in the amount established by my provider__________ (fee per session).

☐ Payment for a no-show or missed session without 24 hours notice.

☐ Payment for a phone or telemedicine session.

☐ Payment for past due sessions.

I understand that the amount charged on my card will be reflected on my credit card statement and that "**Denise Hockley, LMFT**" (or an abbreviated version) will appear on my credit card statement. __________ (Initial).

I agree that this form is valid for the length of therapy and authorization for the use of this card will be canceled at the termination of therapy. __________ (Initial)

____________________________ ___________________________

Signature of Client Date