**Yeshim Oz, MA, LIMHP**

**Licensed Independent Mental Health Therapist**

**Credit Card Payment Policy**

In an attempt to keep my clients’ accounts up-to-date, I have implemented a system of payment. By having your credit card information on file, I can efficiently update your account after each session. You may opt to pay your due with cash, check or using another credit card at each session, however, you need to provide a valid credit card information during your initial consultation.

In addition, my cancellation policy requires 24-hour notice be given if it is necessary to cancel or change an appointment. **Failure to do so will result in a flat fee of $100.00.**

For further information about payment and collection policy, please read Financial Information form carefully before signing it.

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I have been made aware of this policy and understand that my credit card may be charged for therapy services rendered. I also understand that my insurance will not cover cancellation charge and I am fully responsible for this charge as well.

 **Credit Card Information:**

Card Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 V/MC Expiration Date (Month/Year):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 3-Digit CID:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Name of Cardholder:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Address of Cardholder:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Cardholder:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_

If you have any question about this policy, please discuss it with me.