

MAGEE MADRY
COUNSELING SERVICES

Beyond the Journey

Client Name:

(Card Holder) Name on card if different than client:

Card Type: _____

Card Number: _____

Expiration Date: _____

Billing Zip Code: _____

CVV: _____

I authorize Magee Madry Counseling to charge my credit/debit/health account card for professional services. If I do not cancel or reschedule before 24 hours, I recognize that Magee Madry Counseling will charge my card for the full session amount of \$150 for the time that was reserved for me. I understand that there is a 15 minute grace period once my session has begun following such the session will be considered a no show and my card will be charged.

I verify that my credit card information, provided above, is accurate to the best of my knowledge. If this information is incorrect or fraudulent, 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.

Client Initials: _____

Date: _____

Signature: _____

By signing this I acknowledge that I've read, fully understand and agree to all information contained here.

