



Ker Cleary, M.A.
Clearheart Counseling

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Credit Card Payment Consent Form

Client Name _____
Print Last First Middle Initial

Name on Card if different _____

I authorize *Ker A. Cleary, MA, and ProfessionalCharges.com*, to charge my credit/debit card for professional services as follows:

Initial

_____ A one time charge in the amount of \$ _____ for _____ on _____
services date

_____ Recurring charges for services in the amount of \$ _____ per visit

_____ Other (specify, such as “with verbal permission” or “as needed”) _____

_____ I understand and agree that my card will be charged *full fee* for cancellations with less than 24 hours’ notice and for appointments I miss without notice

_____ I understand this form is valid for two years unless I cancel the authorization in writing. I will not dispute charges (“charge back”) for sessions I have received or appointments I missed according to the above policy.

Type of Card: Visa, MasterCard, Discover, Medical Savings/Expense

Credit Card Number _____ - _____ - _____ - _____,

Expiration Date _____ CVV Number _____ (3-digit number in reverse italics on card **back**)

Card Holder’s Billing Address for Credit Card Statements

Street City State Zip

Card Holder Signature _____ Date ____ / ____ / ____

Email address (for receiving receipts for charges) _____

Charges will appear on your credit card statement as ProfessionalCharges.com or some abbreviation of it.