Client Name: _____ ***Date:*** _____

Financial Responsibilities Form

For the financial health of the practice, it is our policy to collect all amounts owed on the day services are rendered prior to your session. Please provide complete payment information for billing which will occur on the day of each session. VISA or MASTERCARD are accepted. ***Checks will not be accepted***.

Your Name: _____ Relationship to Client: _____

Full Name as seen on Card: _____

Type of Card: (***please circle***) VISA ~ MASTERCARD ~ AMEX ~ DISCOVER ~ FSA Card

Card Number: _____

Expiration Date: _____

CSV: _____ Billing Zip Code: _____

Full Billing Address: _____

_____

_____ □ I confirm that the information provided above is true and accurate

_____ □ My signature below gives authorization to bill my credit card for services on the day of each session.

_____ □ I understand that my card will be billed if I fail to cancel within 24 hours of my scheduled appointment.

_____ □ I understand that my bank statement will show the charge originated from "Legacy" or "Legacy Square" or "Legacy Consortium" or "Legacy Counseling" as billing for services (***not the name of your therapist***).

Signature of Card Holder: _____ Today's Date _____

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