

Keith E Poynter, LMHC
1209 11th Street, #4 Bellingham WA 98225
360.410.1751

Credit Card Authorization

Client Name: _____

Responsible Party (if different): _____

Name on Credit Card: _____

Credit Card #: _____

Exp. Date: _____ CCV (on back of Card): _____

Billing Address: _____

City, State, Zip: _____

Phone Number: _____

I understand that payment is due upon receipt of billing statement from Associates in Mental Health (AMH). If payment is not received within **60 days** of date of Billing Statement, I authorize my credit card listed above to be charged for my *full balance*. I also understand that if I need to cancel or reschedule an appointment, I must provide at least **24 hours** of notice. If I do not provide 24 hours notice, my credit card will be charged a cancellation fee. First cancellation fee is \$65.00. Thereafter, the full session fee of \$135.00 may be billed. I authorize my credit card listed above to be charged the cancellation fee if I do not provide 24 hours of notice. At counselors discretion, fees may be waived for an emergency or significant illness that prevents attendance.

Signature below indicates acceptance of above terms and that Keith E Poynter, LMHC has my permission to charge my credit card according to terms listed above.

Cardholder Signature

Date