



## Credit / Debit Card Payment Consent Form

Client Name: \_\_\_\_\_

Name on Card if different than client: \_\_\_\_\_

I authorize Retreat Wellness LLC to charge my credit/debit/health account card for professional services 24 hours before our scheduled appointment. If I do not cancel before 24 hours, I recognize that Retreat Wellness LLC will charge my card as a late cancel or no show if I do not show up for the appointment. I will be billed a late cancellation/no show charge of \$50.00.

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

Signature: \_\_\_\_\_

Initials: \_\_\_\_\_

Date: \_\_\_\_\_