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CREDIT/DEBIT CARD AGREEMENT

WE ACCEPT VISA-MASTERCARD & DISCOVER, ONLY.

With this consent, your credit card will be kept securely on file and fees will be applied under the following conditions. Please initial your approval.

_____ I authorize Healing Pathways, LLC to apply fees or co-payments for services received by Friday of the week in which the services were received.

_____ I authorize Healing Pathways, LLC to apply a full fee for any services missed and not cancelled within 24 hours of its scheduled time.

_____ I authorize Healing Pathways, LLC to apply any fees that are unpaid after 45 days.

_____ I understand that I may revoke this agreement in writing at any time.

Date: _____

Name (as it appears on card): _____

Signature: _____

Card type: _____ Card #: _____

Expiration date: ____/____/____ Security Code (three digits on back): _____

Billing Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____