This document represents your consent to make payment for services rendered. Your treatment is conditional on your signing this consent form without modification.

**FEE POLICY and NO SHOW POLICY:** A fee will be charged for all scheduled sessions. Payment of all fees, deductibles and/or co-pays is required at the time of office visits unless other arrangements have been made prior to the scheduled appointment. It is my responsibility to arrive on time for my appointments, as I understand that a specific amount of time has been allotted to me. **Cancellations must be made 24 hours in advance or I will be responsible for payment for the missed session at 100% of the full fee. Insurance cannot be billed for missed appointments.** Exceptions to this policy are at the clinician’s discretion.

There are several reasons for this policy. A scheduled appointment means that a specific amount of time is reserved for you by your clinician. Twenty-four hours notice will allow the clinician to offer that time slot to another client who is in need of care.

**CREDIT CARD AUTHORIZATION:** I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize Anna Wellman, LCSW, to bill my credit card at the usual fee for professional services including all of the following:

o Appointments that I elect to pay for by credit card

o Missed appointments

o Telephone conversations lasting more then fifteen minutes

o Appointments that I have cancelled (non-emergencies) with less than 24 hours notice

o Returned checks ($15 fee)

Credit card / Debit card type (select one): ☐ Visa ☐ MasterCard ☐ American Express

Card #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration date: \_\_\_\_\_\_\_\_\_\_\_\_ Security Code: \_\_\_\_\_\_\_\_\_

Name as printed on card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_

**CLIENT STATEMENT:** By signing below, I am authorizing Anna Wellman, LCSW to bill my credit card at the usual fee for professional services as described above.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CLIENT SIGNATURE DATE**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRINT NAME**