Warner Family Counseling
Kaylene Warner LCSW

Client Credit Card Consent

The below credit card information, provided by the client or parent/guardian, will be placed on file. By signing this agreement, you are agreeing to allow Warner Family Counseling, PLLC to charge below listed credit card for any "no show, no call" appointments, late cancellations made inside of 24 hours of set appointment, and any telephone or ancillary charges (returned check fees, requested letter or documentation fees, any requested medical record copying fees).

Type of Credit Card (circle): Visa/ MasterCard
Name (as printed on card): ____
Credit Card Account Number: ____
Expiration Date: _________________ 3 Digit Security Code/CVC: _________________

Billing Address for Credit Card: ____

City_________________________ State_______ Zip_____________

Email Address: __________________________________ (to receive electronic copies of receipts)

By my signature below, I also request and provide Warner Family Counseling, PLLC my permission to charge the above listed account for ongoing regular therapy sessions according to the fee schedule, described in the General Policies and Client Consent forms, completed at time of admission/intake.

Printed Name: ____

Signature of Cardholder: ____

Date: ____________________________________