Uplifting Therapy

Licensed Marriage and Family Therapist
Brenda Franks Lic. # LMFT 96217
PH: 530.645.2278 FAX: 530.441.1277

Credit Card Fee Agreement

(As reiterated per the terms of LMFT Agreement of Services Informed Consent document.)

Payments: Your fee for each 45/50-minute session will be $__________, payable via cash, check or credit card (Visa, MasterCard, or Discover). You are expected to pay your session fee at the start of each session unless other arrangements have been made. Telephone conversations, site visits, report writing and reading, consultation with other professionals, releases of information, reading records, longer sessions, travel time, etc. will be charged at the same rate unless otherwise indicated and agreed upon. Credit card information will be kept private by electronic means for billing.

Cancellation Policy: Since the scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24 hours notice is required to reschedule or cancel an appointment. Patients are requested to provide a credit card number that can be used for billing in the event of a late cancellation or no show. The full session fee will be charged to the credit card number provided in the section below for appointments missed without notice or canceled with less than 24 hours' notice, unless we are able to find a mutually agreeable time to reschedule the appointment within the same week.

Credit Card Authorization: In the event of a late cancellation (less than 24 hours' notice) or missed session, ***you will be charged the full session fee.*** Unless otherwise agreed to, the fee will be charged to the credit card account provided below.
_______________________________________ [patient or caregiver/payer name if services are being paid for by someone other than the patient] authorizes Brenda Franks, LMFT, to charge the session fee of $ _________ to the credit card indicated below in the event that I (or the patient if services are being paid for by a caregiver or other adult) do not attend a scheduled therapy appointment without giving a minimum of 24 hours' notice.
CREDIT CARD STATEMENT SHOULD READ: Brenda Franks, LMFT
Card Type (circle/select one): ☐ **Visa** ☐ **Discover** ☐ **MasterCard**

Card #:______________________________ Exp date: ___________

CVC (3-digit on the back of the card): ___________

Name as Printed on Card: ____

Billing Address:____

City ____________________________________ State: _____ Zip code:________________

hello@brendafranks.sprucecare.com

revised 9/30/20

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Authorized Cardholder Signature:_______________________________

Date: ____

I have read the above Fee Agreement document carefully, and I understand it and agree to comply with all its terms and conditions.

_______________________________ ___________________
Patient Signature   Date