Carol Fahy Ph. D., Psy. D.

808-838-9541
CarolFahy.com

CREDIT CARD / DEBIT CARD PAYMENT CONSENT FORM

Please read the following information and then complete the form below:

Cancellations and No Shows: You will be charged for any cancellation that occurs within 24 hours of your scheduled session time. You also will be charged for a no show to your appointment time. The time has been set-aside for you. Please cancel 24 hours in advance of your appointment time to avoid being charged for your session.

I understand that I will be charged for any session that is not cancelled 24 hours before the scheduled time. I also understand I will be charged for No Shows.

Print Name | Signature of Patient | Today's Date

PATIENT NAME: _____
Last Name First Name Middle Initial

NAME ON CARD (IF DIFFERENT THAN ABOVE) _____

I, _____, authorize Carol Fahy Ph.D. to charge my card for professional services as follows:

_____ (Initial) to charge my card for any sessions cancelled within 24 hours prior to my appointment time. The charges will include the amount that the insurance company would pay for the session, the co-pay for the session, and the G.E.T. Tax.

_____ (Initial) and the balance of any fees not paid by my insurance company within 60 days, as indicated above.

TYPE OF CARD: ☐ VISA ☐ MASTERCARD ☐ DISCOVER EXPIRATION DATE: _____/_____

CARD NUMBER: _____ - _____ - _____ - _____ CVV NUMBER: _____

CARD HOLDER'S BILLING ADDRESS FOR MONTHLY CARD STATEMENTS

_____
Street City State Zip Code

If I have questions about these charges, I agree to contact my provider. I agree that I will not pursue a refund directly through my credit / debit card company, bank, or financial institution. If any of my actions yield a chargeback for any reason, I agree to pay any and all penalty fees incurred by my provider.

CARDHOLDER SIGNATURE Today's Date

FOR OFFICE USE ONLY:

Patient ID#: CF#: Date First Seen: