TRANSFORMATIONS
THERAPY OF ATLANTA

Payment Consent Form

Name on Card: ____
(This should be patient name)

If not, please provide patient name: ___________________________

If name on card is different from patient name, please provide your relationship to the patient and your contact information (phone and address): ______________
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This form must be completed and signed by the person authorizing payment and whose name appears on the card.

I authorize, Transformations Therapy of Atlanta, LLC operating under the billing of We Counsel to charge my card for the following:

1. **All Psychotherapy sessions rendered; fee is determined by the length of the session; pricing is available on our website.**
2. **Any late cancellation fee or no show fee; the equivalent of $75**
3. **Any unpaid balances related to services rendered or missed sessions**

I have provided Transformations Therapy with the following card number to cover the cost of treatment as detailed above.

Card number ending in ___________ (last four digits)
___Visa ___Mastercard ___Discover ___American Express

You may provide this card to your therapist directly or enter the information on the secure client portal, We Counsel. Your credit card information will be saved on the encrypted client portal site provided by We Counsel for your privacy.

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Signature of Authorizing Person and Date