JANE SWEENEY • LPC-S • NCC

295 Hughes Rd, Suite B • Madison, AL 35758

Credit Card/Debit Payment Form

Date ____/____/____

Name as on card _____

Mastercard _____ Visa _____

This card is Debit _____ Credit _____

Card Number _____

Security Code _____ (on back of card, 3 numbers following signature line)

Expiration Date _____/_____

I authorize Jane Sweeney, LPC-S, NCC or Sojourner Counseling Center LLC to charge my credit or debit card fro account balances after insurance reimbursements and my prior payments including any charges for late cancellations or missed appointments. I agree to pay the amount of my balance according to the card issuer agreement.

Charges will be identified on my bankcard monthly statement as Sojourner Counseling Center LLC. I affirm that the information that I have provided in this authorization is correct , current and valid. If I close the bankcard account on file or if my current card expires, I agree to provide my provider with updated information giving current valid bankcard information.

In order to avoid fee increases, this office does not offer billing services. If I am notified about a bankcard denial based on the authorization on file and do not provide updated or valid alternative bankcard information within five business days, I understand that my account will be accessed a 5% monthly increase until the balance is paid.

Signed: _____
Credit Card Holder

We accept medical savings account cards or flexible spending account cards.