Keweenaw Counseling Services PLLC
Kyle Duquette LMFT
Credit / Debit Card Payment Consent

Client Name:_____

(Card holder) Name on card if different:_____

Card type:_____

Card number:_____

Expiration date:_____ 3 digit security code:_____

I authorize Keweenaw Counseling Services PLLC and Kyle Duquette LMFT to charge my credit/debit/health account card for professional services. This includes any deductible or co-pay required by insurance, or the standard $120 fee per 60 minute session. I understand that if I do not show up for my appointment at the scheduled time, or do not give 24 hours' notice of cancellation, I will be charged the $80 missed appointment fee.

I verify that my credit card information provided above is accurate to the best of my knowledge. If this information is incorrect or fraudulent, or if my payment is declined, I understand that I am responsible for the entire amount owed and any interest or additional costs incurred if denied.

Client initials:_____

Card holder initials (if different than above:_____

Client signature:_____Date:_____