KIRSTEN OELKLAUS
LSCSW, CEDS

# Credit Card Payment Consent Form

Patient Name:_____
Print Last First Middle Initial

Name on Card (if different)_____

I authorize Kirsten Oelklaus, LSCSW to charge my credit/debit card for professional services as follows:
All agreed upon service fees upon a completed session. In addition, I authorize this credit/debit card to be used for any and all No Show/Late cancel fees of $150.00 as outlined in the signed consent for treatment.

Type of Card: ☐ Visa ☐ Mastercard ☐ Other (Specify):_____

Credit Card Number_____-_____-_____-_____

Expiration Date_____CVV Number (3 digit on back of card)_____

Card Holder's Billing Address for Credit Card Statements

_____
Street City State Zip

If I have questions about these charges, I agree to contact my provider, Kirsten Oelklaus, LSCSW at (913)631-3800 ex 107. 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 fee(s) incurred by my provider.

Card Holder Signature_____, Date ___/___/___.

Charges will appear on your credit card statement as Kirsten Oelklaus, LSCSW, or Clover/Bank of America.

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