Jeremy J. Lanning MA, LPC
Counseling & Psychotherapy
3309 Winthrop Ave, Suite 99
Fort Worth, TX 76116
817-703-7469

GUARANTEE OF PAYMENT

I, ____, hereby authorize

____ of **Counseling & Psychotherapy,** to charge the credit card listed below for any balance I accrue that is outstanding from non-payment on past due accounts. I also authorize the charge of my credit card if I miss a scheduled session or cancel within less than 24 hours.

____
Credit Card *Credit Card Number* *Security Code* *Ex. Date*

____
Name as it appears on card

____
Billing Address (please include zip code)

____
Phone number & email address

____ _________________________
Signature *Date*

____ _________________________
Witness *Date*

****<u>If the financial responsible party is different than the client for adult clients</u>**
please complete the following release:

I, ____, give permission for **Counseling & Psychotherapy** to communicate financial information regarding my therapy sessions with:

Name: _______________________________ Phone number: _____________________________

____
Signature