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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

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

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

Name: _____ Phone number: _____

Signature