Credit / Debit Card Payment Consent Form

Client Name: ________________________________

Name on Card if different than client: ____________________________

Phone number: ____________________ *you will receive a text from IvyPay to initiate payment

____ I authorize Root To Crown Healing & Wellness, LLC to charge my credit/debit/health account card for professional services up to 48 hours before our scheduled appointment via IvyPay or other card processing.

____ If I do not cancel before 48 hours, I recognize that Cassandra Sawyer, MA, ATR-P, RYT200 will charge my card the full session amount for late cancels or no show if I do not show up for the appointment.

____ I will be billed for a session rate of $_____

____ 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. I also understand by signing and initialing this form that if no payment has been made by me, my balance will go to collections if another alternative payment is not made within thirty days.

Signature: ___________________

Print Name: _________________

Date: ______