



Credit/Debit Card Payment Consent Form/ Sliding Scale Fee Agreement

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 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 as a late cancel or no show if I do not show up for the appointment (100% of session fee).

We have made an agreement to an adjusted sliding scale rate of \$_____/hour. This arrangement will be revisited every 3 months to determine if financial assistance is still needed and/or if the therapist is still able to continue this arrangement.

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: _____ Date: _____