MIRACLE Counseling

CREDIT CARD PAYMENT – SELF PAYMENT

Patient's Name: Date:

INSURANCE WAIVER AND AGREEMENT TO SELF-PAY

I have selected not to use my insurance for my counseling sessions, and I understand that opting out of using my insurance means I must pay out of pocket for the counseling sessions.

Patient's Name Patient's Signature Date

CREDIT CARD INFORMATION	
Cardholder Name:	
Card Number:	
Expiration Date:	(CVV):
Zip Code:	
☐ Visa	☑ Discover
☐ American Express	☐ Mastercard
☐ Other:	

DEBIT CARD INFORMATION	
Cardholder Name:	
Card Number:	
Expiration Date:	(CVV):
Zip Code:	
☐ Visa	☐ American Express
☐ Discover	☐ Mastercard
☐ Other:	

NOT APPLICABLE ☐

INCLUDE A COPY (FRONT & BACK) of CREDIT CARD/ATM & IDENTIFICATION

*****Good Faith Estimate is available upon request*****

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