Amber Martin, LMFT
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Soquel, CA 95073
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626-234-5113

Client Policies and Payment Information

Client Information

Date:_____

First Name:_____ Last Name:_____

Name of Person Responsible for Payment:_____

Relationship to client:_____

Address:_____

City:_____State:_____ Zip:_____

Preferred Phone:_____

Preferred Email:_____

Policies and Payment Information

please initial as proof of understanding

Billing _____
Amber Martin, LMFT accepts payment in the form of cash, check, american express, discover, visa or mastercard. Payment is expected at time of appointment. If you would like to set up re-occuring payments, please fill out credit card authorization on back. Once the information is entered into our secure system all paperwork is destroyed onsite.

Treatment of Minors _____
I, as a parent/guardian of a minor receiving therapy, understand that I have been advised to remain on the premises during a session and waive any claim resulting in my failure to do so.

Paperless Policy _____
I understand that Amber Martin, LMFT maintains a paperless office. All coded invoices are delivered via email. It is my responsibility to update the office with any changes to my contact info.

Financial Responsibility _____
I understand that Amber Martin, LMFT does not accept any health insurance. Payment is my sole responsibility and will be paid at time of appointment.

Cancellation Policy _____
Cancellations should be communicated via phone or email no less than 24 hours before the scheduled session time. Cancellations due to emergency or illness can be made at any time. Please do not bring sick children to therapy. No-show appointments and non-emergency cancellations made less than 24 hours in advance will be billed the normal session rate. We reserve the right to discontinue an appointment time if more than 3 sessions in a row are cancelled.

Credit Card Authorization

Name on Card: _____

Type of Card (circle): VISA Mastercard AMEX Discover

_____ check here if FSA/HSA card

Card Number: _____

Expiration Date: _____

V-Code: _____

___ Check here if you only want the initial appointment on this card

___ Check here if you would like all invoices to be auto-pay on appointment date

By signing this form, you authorize Amber Martin, LMFT to charge your card as noted above. It is your responsibility to maintain an active card on file.

_____ _____

Signature Date

This paper will be destroyed once credit card is processed.