Elizabeth A. Willems, PsyD
INTERCULTURAL PSYCHOLOGICAL SERVICES

CLIENT PAYMENT AUTHORIZATION

Elizabeth Willems PsyD Intercultural Psychological Services
+1 617-402-5515

CARDHOLDER INFORMATION

Client Name	
Name on Card (if different)	
Card Number	
Security Code (CVV)	
Billing Zip Code	
Expiration Date (MM/YY)	

DATA SECURITY AND EXPLICIT CONSENT

I, the undersigned, EXPLICITLY and VOLUNTARILY AUTHORIZE the practice of Elizabeth A. Willems, PsyD to securely process and store my payment information for the sole purpose of payment for healthcare services and operations.

- HIPAA: I understand that this information will be used for Treatment, Payment, and Healthcare Operations as defined in the practice's Notice of Privacy Practices (NPP).

- Data Processors: I acknowledge that the practice uses third-party vendors, Theranest (Ensora) and Stripe, Inc., for secure processing and storage. The practice maintains a Business Associate Agreement (BAA) with these vendors to ensure my data is protected according to USA federal and state laws.

- Right to Revoke: I understand this consent is OPTIONAL and I can REVOKE IT IN WRITING at any time. Revocation will not affect services already rendered or charges already incurred.

Client Initial (guardian for minor clients): ____________

FINANCIAL AGREEMENT & FEE POLICY

I authorize the practice of Elizabeth A. Willems, PsyD to charge my card for agreed-upon fees (co-pays, self-pay, no shows, late cancels, etc.) up to 24 HOURS BEFORE my scheduled appointment.

Fee Category	**Condition**	**Charge Amount**
Late Cancellation	If I cancel less than 24 hours before my appointment.	Full Session Charge (determined individually with provider).
No-Show	If I miss the appointment entirely.	Full Session Charge (determined individually with provider).
Billing Name	Charges will appear on my statement as "WILLEMS PSY SERVICES."	

DECLINES & COLLECTIONS WARNING

I verify the card information provided is accurate.

- DECLINED PAYMENT: If payment fails, I am responsible for the entire amount owed, plus any resulting fees or interest.
- DEBT COLLECTION: I understand my outstanding balance may be sent to a collection agency if an alternative payment is NOT made within THIRTY (30) DAYS of the balance due date.

Client (guardian for minor clients) Signature: ______________________________

Cardholder Signature: ______________________________

Date: ______________________________

ACUERDO FINANCIERO Y POLÍTICA DE TARIFAS

Autorizo a la práctica de Elizabeth A. Willems, PsyD a cargar mi tarjeta por las tarifas acordadas (copagos, pago propio, cancelaciones tardías, etc.) 24 HORAS ANTES de mi cita programada.

Categoría de Tarifa	**Condición**	**Monto del Cargo**
Cancelación Tarda	Si cancelo menos de 24 horas antes de mi cita.	Cargo Completo de la Sesión (determinado individualmente con el proveedor).
No Presentación	Si falto a la cita por completo.	Cargo Completo de la Sesión (determinado individualmente con el proveedor).
Nombre de Facturación	Los cargos aparecerán en mi estado de cuenta como "WILLEMS PSY SERVICES."	

ADVERTENCIA DE RECHAZOS Y COBROS

Verifico que la información de la tarjeta proporcionada es precisa.

- PAGO RECHAZADO: Si el pago falla, soy responsable del monto total adeudado, más los cargos o intereses resultantes.
- COBRO DE DEUDAS: Entiendo que mi saldo pendiente puede enviarse a una agencia de cobros si NO se realiza un pago alternativo dentro de los TREINTA (30) DÍAS de la fecha de vencimiento inicial del saldo.

Firma del Cliente (o del Tutor/Padre de familia para clientes menores de edad):

Firma del Titular de la Tarjeta:

Fecha: