Sharon Sanborn, MA, LMHC, ATR-BC, CHT
18 W. Mercer St., Suite 360, Seattle, WA 98119 Tele: (206) 283-9767
Sharon@SharonSanborn.com www.SharonSanborn.com

By signing the signature line below, I agree to be financially responsible for costs that accrue from counseling/coaching/hypnotherapy and agree to be financially responsible for No Show and Less than 24 hour cancellation fees in accord with Sharon Sanborn's Disclosure Statement.

Name _____ **Signature** _____

Date _____

CreditDebit/HSA Card Payment agreement. I agree to have my credit card information securely stored by Sharon Sanborn. I authorize Sharon Sanborn to charge my credit card for any outstanding bills (typically these are for such items as co-payments and deductible amounts for health insurance, No Show and Less than 24 hour cancellation fees).

Name on card: _____

Card Number: _____

Expiration date: _____ **Zip Code:** _____

Security/Verification Code (3 digit number on back of card): _____

Card Holder Signature: _____ **Date** _____

Primary Health Insurance/EAP Company _____

Identification # _____ **Group #** _____

If not self, Insured/Subscriber's Name _____

Relationship to you _____

Insured's Date of Birth _____ **and Employer** _____

If another person is responsible for costs: Name _____

Address _____ **City** _____

Zip _____ **Phone** _____

I authorize any release of information required to process insurance/EAP claims and authorize my Health Insurance/EAP benefits to be paid directly to Sharon Sanborn. I am responsible for any co-payments or deductible charges. This agreement is in effect immediately.

Client Signature _____ **Date** _____