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## CREDIT CARD AUTHORIZATION • NO SHOW/LATE CANCELLATION

**Heather Macmillan, Registered Counselling Therapist**

In order to provide you with the best possible care, **a minimum of 24 hours notice** is required to cancel appointments with Heather Macmillan, RCT. **Please note there are no exceptions to this policy.**

I, \_\_\_\_\_, give Inner Ocean Healing Centre the authorization to charge my credit card for half of the session fee, specifically **sixty dollars (\$60)** for each 55 minute missed therapy session **or seventy-two dollars, fifty cents (\$72.50)** for each 80 minute missed therapy session where 24 hours notice is not given.

This credit card will also be used for all fees that have not been paid within 30 days (unless other arrangements for payment have been agreed upon in writing between the client and Heather Macmillan, RCT).

I will provide a receipt for all payments upon request.

I understand that I may revoke this agreement at any time by providing a request in writing. I am also aware that when psychotherapeutic services rendered by Heather Macmillan, RCT have ended, this form shall be shredded once I am terminated from treatment.

I am requesting that this card be used for payment of services and cancellation fees: ☐ Yes ☐ No

Name on card: \_\_\_\_\_

Card Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Expiration Date: \_\_\_\_\_ / \_\_\_\_\_ Code: \_\_\_\_\_

Street Address: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Email address for receipt: \_\_\_\_\_

Patient Name (printed): \_\_\_\_\_

Patient (or Parent/Guardian)/Card Holder Signature: \_\_\_\_\_ Date: \_\_\_\_\_