Credit Card Authorization Form

Name on the Card: ______________________________

Type of Card: Visa ☐ MC ☐ AmEx ☐ Discover ☐

Other ☐ ____________________

Account Number ______________________________

Expiration Date ____________________

Security Code ____________________

Billing Address ______________________________

City, State, Zip ______________________________

Phone Number ______________________________

Your EWB Clinician will charge your account for:

- Deductible amount not met
- Copayment/Co-insurance amount
- Full Fee for Late Cancellations (less than 24 hours advanced notice) or Missed Appointment (with no notice). ***Please note 1 Late Cancellation or Missed Appointment is waived per year.***

By signing this form, you authorize ______________________________

to charge your card for the amount(s) listed above.

You will be notified by your Clinician or EWB when your card is charged. This authorization will be shredded at the termination of the therapeutic relationship.

Signed: ______________________________ ____________________
Date

6723 Whittier Avenue, Suite 207 McLean, Virginia 22101
(703) 475-6478 Fax (571) 730-3689
www.evolutionarywellbeing.org