



Integrative Therapy of Greater Washington
5818 B Hubbard Drive
Rockville, Maryland 20852
(301) 468-4849
itgwbilling@gmail.com

Credit Card Authorization

I authorize Integrative Therapy of Greater Washington to charge my credit card as noted below for all appointments, including non-emergent cancellations without 24 hours notice. Additionally, my card will be charged for additional time or services provided (e.g. phone conversations lasting longer than five minutes, letter writing, record reviews, court appearances, calls to schools and other agencies, consultations with other professionals).

TODAYS' DATE: _____

NAME (Please Print) _____

Child's Name: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

HOME TEL. #: _____

EMAIL ADDRESS: _____

CREDIT CARD: _____ MasterCard _____ Visa _____ American Express

NAME ON CARD: _____

CREDIT CARD NUMBER: _____

EXPIRATION DATE: _____ **SECURITY CODE:** _____
(3 or 4 digit code on back of card)

SIGNATURE: _____