Integrative Therapy of Greater Washington

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Credit Card Authorization

I authorize ITGW 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).

DATE:

NAME (*Please Print*):

_____

Client's Name (if different)

_____

ADDRESS:

_____

CITY, STATE, ZIP:

_____

HOME TEL. #:

_____

EMAIL ADDRESS:

_____

____

CREDIT CARD:____MasterCard ___Visa ____AmEx _____Discover

NAME ON CARD:

_____

CREDIT CARD NUMBER:

_____

EXPIRATION DATE: _____ **SECURITY CODE:**_____

(on back of card)

SIGNATURE:

_____