Barbara R. Evans, EdD, LCPC

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Credit Card Authorization

Barbara R. Evans, EdD, LCPC kindly requests to retain a valid credit card to reserve appointments and to ensure payment in the event reimbursement is not made by an insurance company or otherwise. Thank you for your understanding and cooperation.

I authorize Barbara R. Evans, EdD, LCPC to charge my credit card for services rendered. I understand that if I do not show for my scheduled appointment, or if I fail to cancel an appointment within 24-hours of my scheduled appointment time, I authorize Barbara R. Evans, EdD, LCPC to charge my credit card the amount of $100. Outstanding balances may be charged via this credit card unless other payment arrangements have been made.

Credit Card Information

Credit card type: ___Visa _____ Master Card

Name as it appears on credit card: _____

Billing address associated with credit card:

_____
Street Apt/Unit #

_____
City State Zip

Phone: _____- _____ - _____

Email: _____

Credit Card Number: _____

Expiration Date: _____ / _____ CCV _____

Name (please print): _____

Signature: _____ Date: _____

Signature of Therapist: _____ Date: _____