Julian R. Harris, MSW, LICSW
1633 Q Street NW, Ste 210
Washington, DC 20009
202-335-3119

Credit Card Authorization and Information Form

My office requires that each client keep an up-to-date credit card on file. This credit card will only be used in the following scenarios:

1. You terminate treatment and have a balance on your account*
2. You have missed or cancelled a session with fewer than 24 hours notice you will be charged the full amount
3. You have missed two payments and are scheduled to come in for another session. In this case, the balance on your account AND the full amount for the upcoming session will be charged IN ADVANCE to hold your slot.
4. Another payment arrangement has been discussed and agreed upon in advance.

Your signature below authorizes me to charge the card on file in the situations listed above. An email for the charge will be sent to you if you wish to provide an email address.

_____	_____	_____
Client Name (print)	Client Signature	Date

Name on Card: _____

Credit Card Billing Address (city, street, zip): _____

Type of Card: Visa MasterCard Discover

Credit Card Number: _____-_____-_____-_____

Expiration Date: _____ /_____

Security/CVV Code: _____

Email Address (only if requesting a receipt): _____

*Please note that if you terminate services with a balance on your account, I will also send a paper receipt to your address on file indicating the dates of services and related charges.