Heather H. Kirby, LCSW, CSAC, M.Ed.
Kirby Creative Clinical Solutions, LLC
3929 Old Lee Hwy; Unit 92-D
Fairfax, VA 22030
703-409-2571
Tax ID # 27-2924949

Credit Card Authorization Form

CARDHOLDER INFORMATION

Name:_____

Billing Address:_____

_____

City:_____ State:_____ Postal Code:_____

Email: _____

Phone: _____

CREDIT CARD INFORMATION

Credit Card Type: □ MasterCard □ Visa

Number:_____

Expiration Month:_____ Expiration Year:_____

Security Code:_____ Billing Zip code: _____

STATEMENT OF AUTHORIZATION

I authorize Heather Kirby, LCSW to charge my credit card for therapy services provide to

(client) _____.
I have been given the fee structure for services and agree to pay accordingly. I understand there is a $65 charge for sessions missed with less than 48 hours advanced notice and that these may not be eligible for reimbursement from my insurance company.

Cardholder Signature: _____ Date_____/_____/_____