PASSPORT, a program of
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: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Email: _____ Phone: _____

CREDIT CARD INFORMATION

Credit Card Type: ☐ MasterCard ☐ Visa

Number: _____

Expiration (Month / Year) _____/_____

Security Code:_____ Billing Zip code: _____

STATEMENT OF AUTHORIZATION

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

_____.

I have been given the fee structure for the PASSPORT Program and agree to pay accordingly. I understand that I will be billed for missed sessions and that these may not be eligible for reimbursement from my insurance company. My initials below indicate my preference in regard to payment.

_____ I prefer to pay by check at the beginning of each week and have my credit card charged only when there is a balance past due.

_____ I welcome the convenience of having my credit card charged at the beginning of each week.

Cardholder Signature: _____ Date _____/_____/_____