Credit Card Pre-Authorization Form

I authorize ***Edina Counseling Center*** to keep my signature and credit card information on file and to charge the designated credit card for the following:

_____ My balance when I am in the office.

_____ My balance as I so instruct via telephone, text or e-mail.

_____ My balance remaining after I have terminated therapy.

Credit Card Type: ____ Visa ____ Mastercard ____ Discover ____ American Express

____Health Savings Acct

Patient Name: _____

Cardholder Name: _____

Name as it appears on card (if different): _____

Cardholder Billing Address: _____

City: _____ State: ____ Zip: _____

Credit Card Number: _____

Expiration Date: _____ Security Code: _____

Cardholder Signature: _____ Date: _____

Evolving Woman Enterprises, Inc.
dba Edina Counseling Center
7400 Metro Boulevard, Suite 211
Edina, MN 55439
Office: 952-835-1616 Fax: 952-835-6182