The Well Counseling
16300 Mill Creek Blvd. Suite 204
Mill Creek, Washington 98012
425-359-4404

By signing this form, you give us permission to debit your account for the amount indicated on or after the indicated date. This is permission for therapeutic treatment fees accrued while in treatment with and does not provide authorization for any additional unrelated debits or credits to your account. Credit cards may be run in the event that you forget to bring cash, check or a valid credit card to your session. Credit cards will also be debited in the event that you fail to give adequate notice by phone of missing an appointment. A receipt of credit card processing will be sent to the email or phone provided below.

Please complete the information below:

I, _____ (full name printed) authorize The Well Counseling Services to charge my credit card account indicated below (your card may also be copied for our records). Fees accrued for missed appointments or failure to provide payment at the time of service will be processed via credit card at a rate of $160.00 per 45-minute session, $190.00 per 53-minute session, and $250.00 per 70-minute session.

Billing Address: _____ Phone: _____

City, State, Zip: _____ Email: _____

Account Type: ☐ Visa ☐ MasterCard ☐ AMEX ☐ Discover

Cardholder Name _____
Account Number _____
Expiration Date _____
CVV2 (3-digit number on back of Visa/MC/Discover, 4 digits on front of AMEX) _____

I authorize The Well Counseling Services to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above, for the amounts indicated above only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

SIGNATURE _____ DATE _____