

# **WELL STREET**

626 E. Chapman Avenue ♦ Orange, CA 92866  
(714) 730-WELL (9355) • Fax (714) 760-7602

## **Credit Card Authorization**

I, \_\_\_\_\_, hereby give permission for Well  
*Cardholder Name*  
Street Psychological Group, Inc. to charge my credit card (information  
listed below) for the services rendered by \_\_\_\_\_  
*Therapist or Clinician Name*  
in the amount of \$ \_\_\_\_\_.

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

## **Credit Card Information**

*Please fill out completely. Thank you!*

Name on Card: \_\_\_\_\_

Type of Card: \_\_\_\_\_

Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

Billing Address: \_\_\_\_\_

City, State Zip: \_\_\_\_\_

Special Instructions:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_