e•volve
therapeutic center
develop • progress • advance
www.evolvetherapeuticcenter.com
304 W. Mondamin St. Suite 104 Minooka, IL 60447 Mailing address: PO Box 608 Minooka, IL 60447
Main Phone: 815-274-7308 Fax: 815-290-5101 Email: evolvetherapeuticcenter@gmail.com

Client Name: _____

Name on Card (if different): _____

I authorize Evolve Therapeutic Center to charge my credit/debit card for professional services as follows:

❏ This visit only, for the amount of $ _____.

❏ All visits in the next 12 months, beginning _____/_____ /_____, not to exceed $ _____ total.

❏ Recurring charges, date(s) of service _____ /_____ /_____ to _____ /_____ /_____, not to exceed $_____,

❏ ____ monthly, ____ semimonthly, ____ weekly, ____ per visit.

To charge my card for the balance of fees not paid by my insurance company within 90 days, as indicated above.

Type of Card:_____

Card Number _____ - _____ - _____ - _____

CVV Number _____Expiration Date _____

Card Holder's Billing Address for Credit Card Statements

_____

Street *City* *State* *Zip*

If I have questions about these charges, I agree to contact my provider. I agree that I will not pursue a refund directly through my credit/debit card company, bank, or financial institution. If any of my actions yield a chargeback for any reason, I agree to pay any and all penalty fee(s) incurred by my provider.

Card Holder Signature _____

Date