CREDIT CARD AUTHORIZATION

Please complete the following information. This form will be securely stored in your clinical file and may be updated upon request at any time.

I, ____, authorize Shelley White, LMHC to charge my credit card for professional services as follows:

Please Initial:

_______ Agreed upon recurring charges for 'per visit' services.

_______ I understand and agree that my card will be charged full fee for appointments I miss without 48-hr notice as agreed to in the Therapist Disclosure Form I've signed.

_______I agree that my card will be charged for the balance of charges not paid by me or my insurance (such as deductibles and copays).

_______ I understand this form is valid for one year unless I cancel the authorization. I will not dispute charges ("charge back") for sessions I have received or appointments I missed according to the above policy.

Visa MasterCard Debit Card

Card #: ____

Expiration Date: ____

Name as Printed on Card: ____

Verification/Security Code (the 3-digit code on back of card by signature line): ______________________________

Billing Zip Code: ____

Email Address: ____

Signature	Printed Name	Date