Shuman Psychotherapy PLLC
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CREDIT CARD AUTHORIZATION FORM

Shuman Psychotherapy PLLC requests that you provide your credit card information below. If you choose to pay by credit card your credit card will be charged $_____ after each session on the day the session occurs. If you choose to pay by cash or check, your credit card will only be charged if your account is past due and/or for any additional fees you and/or your minor child/ren incur such as late cancellation or no-shows fees.

□ I authorize Shuman Psychotherapy to charge my credit card $_____ after each session and for any and all additional fees I incur.

If your credit card does not go through, you do not have a credit card, or you do not wish to provide your credit card information, in the event your account remains past due for sixty (60) days, your account may be sent to collections. Shuman Psychotherapy reserves the right to send your account to collections, in accordance with Shuman Psychotherapy's policies and procedures; at any time after your account is considered past due.

By signing this authorization form, you agree to notify Shuman Psychotherapy of any changes to your credit card information such as a new expiration date or when your credit card has been cancelled, lost, stolen, or revoked. A new form must be submitted if information such as the list of authorized users and the credit card account's expiration date is amended.

SHUMAN PSYCHOTHERAPY
ONLY ACCEPTS THE FOLLOWING CREDIT CARDS:

□ VISA □DISCOVER □AMERICAN EXPRESS □ MASTERCARD

Name on Credit Card:_____

Type of Credit Card: Visa __ MasterCard __ Discover ___ American Express ___

Credit Card Number_____

CCV Code: _____ Expiration Date :_____

Card Holder's Full Address, including zip code (the mailing address for your Credit Card statements):

_____

_____

This credit card authorization form will remain in effect and on file at Shuman Psychotherapy unless revoked in writing or until the therapeutic relationship is terminated, at which time, authorization to charge your credit card will be revoked, unless an outstanding balance remains on your account after termination. Shuman Psychotherapy will not share your credit card information with any third-party without your consent. Your credit card information will be kept confidential.

Please check one:

□ Card Holder is the client receiving services from Shuman Psychotherapy.

I hereby authorize Shuman Psychotherapy to charge the above credit card number for payment of the counseling fees I incur, which shall include late or past due fees or fees related to cancellations or no-shows. I understand that my credit card will be billed in accordance with the authorizations listed above.

_____ _____

Client Signature DATE

□ Card Holder is a third-party payer for the client receiving services from Shuman Psychotherapy.

I_____, hereby authorize Shuman Psychotherapy to charge the above credit card number for payment of the counseling fees (Client)_____ incurs, which shall include late or past due fees or fees related to cancellations or no-shows. I understand that my credit card will be billed in accordance with the authorizations listed above. I understand as a third-party payer that I am only entitled to receive information concerning payment and that this Credit Card Authorization Form does not authorize me to receive any confidential and protected information about Client beyond payment.

_____ _____

Third-Party Payer's Signature DATE

I, _____, authorize Shuman Psychotherapy to communicate with the above Third-Party Payer solely as it may relate to payment for services I receive from Shuman Psychotherapy.

_____ _____

Client's Signature DATE