**Melissa Shane Counseling Services, LLC**

**Credit Card Authorization**

**I give Melissa Shane, LCPC, permission to charge my bank card for:**

**Client Signature:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I understand and authorize that all copays and/or deductibles over 30 days past-due will be charged to client credit card as denoted below. The full balance owed on client account will be charged to the card after 30 days past due.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I understand and authorize that court fees, letter-writing fees, returned check fees, and telephone consultations over 10 minutes will be charged to this account on the same day of service and/or the same day client account becomes 30 days past-due. Any out of session related fees stated above will be charged at the rate of $175/hour, billed in 15 minute increments ($43.75 per 15 minutes). I also understand and authorize that a bill will be mailed to my home address indicating such charges if charges are made.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** I authorize my credit card to be charged $ \_\_\_\_\_\_\_ after each

 counseling session.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I agree to bring a check or cash to each session in the amount of

 $ \_\_\_\_\_\_\_ .

**Type of Card MC Visa Discover**

**Name on Card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Please print)**

**Card No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Expiration Date: \_\_/\_\_ Zip Code on billing statement: \_\_\_\_\_\_\_\_\_**

**CVV2: \_\_\_\_\_ (3-digit number on back of card)**

**Authorizing Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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