Melanie Chung-Sherman, LCSW PLLC
Empathy. Encouragement. Empowerment.

CREDIT CARD AUTHORIZATION

Client's Name____

Circle one: Visa Mastercard AMEX Discover

Name as it appears on card:____

Card number:____

Expiration Date:____________________________ **CVC (3-digit code):**_____

Zip code______________

Debit Card yes______ **no** ________

Driver's License #______________________________

****I request a call/text/email before card is charged yes____ no____**

*****If my balance is outstanding past 60-days of services rendered OR I cancel/no-show less than 24-hours prior to my appointment, I agree to the charges related to the fees agreed prior.***

I authorize the office of Melanie Chung-Sherman, LCSW, PLLC. to charge any outstanding balances on my account to the above credit/debit card. I understand that I will be mailed a receipt upon request after the card is charged.

I understand any late cancellation fees fees will be assessed utilizing the information provided.

I understand that this information will be held confidentially and in full compliance with all laws relating to the protection of patient information. I have given complete and accurate information regarding this credit card authorization.

Card Holder or Authorized Person's signature:

____

Printed Name

____

Signature

Date__________________________