Shuck & Associates, PLLC

CREDIT CARD PRE-AUTHORIZATION

For use by Shuck & Associates, PLLC only

I, ____ authorize Christine Shuck

(Print Name) (Provider Name)

to keep my signature on file and to charge my account for the following:

☐ Completed session @ consented rate
☐ No-Show/Late-Cancellation Notice (Full payment due)
☐ NS/LC rescheduled session ($50 fee)
☐ Rejected payment fee = $40
☐ Cases in which the other form of payment was rejected (i.e. bounced check) = $40

I understand that my card will be charged per checked reasons above unless I notify the provider that I want to use another payment method. I understand my provider will notify me of any fees or payments due prior to charging my account. **I understand this is a notification and not a request, and that by signing this form, I give consent for all future charges.** I agree that this form is valid for the length of therapy and authorization will be canceled at termination or per my request for all cards listed on this form.

Signature: ____ Date: _____/ _____/ _____

(Circle)	CARD		START	STOP	INITIAL
V MC AE D	Ending: _____________	Expires: _____/ _____	__________	_________	_______
V MC AE D	Ending: _____________	Expires: _____/ _____	__________	_________	_______
V MC AE D	Ending: _____________	Expires: _____/ _____	__________	_________	_______

Cut and Shred Below Line (Card Information)

Card Holder's Name: ____ Billing Zip Code: ___________________

Card Number: ____ Expiration: ____/ ____ CVC: _______

Card Holder's Name: ____ Billing Zip Code: ___________________

Card Number: ____ Expiration: ____/ ____ CVC: _______