**Charles S. Morris LCSW**

**15 Larchmont Road**

**Asheville NC 28804**

**(828) 424-5646**

[**Morristherapy54@gmail.com**](mailto:Morristherapy54@gmail.com)

**Financial Agreement and Authorization To Charge Credit Card**

• Co-payments are due at the time of service.

• Insurance policies are contracts between you and your insurance company. I file these claims as a courtesy and try to help with problems, but you need to resolve those beyond my control.

If insurance is not paying within a reasonable time (45 days), you will be responsible for full payment.

• If I am not covered by your insurance company, full payment is due when services are provided.

• Any phone conversation over 5 minutes will be charged at a prorated fee based on $ 95.00 per hour. This is not covered by your insurance company.

• Any appointments scheduled but not kept, as well as any appointments cancelled within 24 hours of scheduled time will be charged between 50-100% of the regular fee. This is not covered by your insurance company.

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name on Credit Card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Zip Code of Credit Card Billing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number of Cardholder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Credit Card Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Security Code/CVV: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• I authorize Charles S. Morris LCSW to charge my card for office charges.

• I understand that if my credit card does not accept the charge, I will immediately make the payment to the practice.

• I understand that I may cancel this authorization at any time, but by doing so, I acknowledge that the balance owed will be due & paid in full.

• I acknowledge that credit card transactions could be linked to Protected Health Information.

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Signature of Card Holder Date