

**Jose Morell, LMHC, LPC, LADC I, LLC**

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Credit Card Authorization Form

CREDIT CARD “on file” AUTHORIZATION FORM for my convenience of payment of deductibles, co-payments, private pay fees and cancellation fees, to Jose Morell, LMHC, LADC I for services rendered, I am providing my credit card, debit card or health spending flex card information to be kept on file and to be billed to my account within two business days of receiving services or upon incurring fees. Confirmation of payment can be made available upon request. I understand that credit card information will be kept confidential and will be loaded into a HIPPA electronic medical record platform. It is my responsibility to provide an updated card information as needed. This is an optional service. I am not required to provide this information. If I choose not to provide this information, I understand that all deductibles, co-payments, private pay and cancellation fees must be paid at the time of treatment by check to Jose Morell, LMHC as an alternative to keeping an authorized card on file. Cash will be accepted in exact amounts only. I understand that this practice requires a zero-balance due at all times. I understand that his authorization expires upon termination of treatment.

Name on Card:

Client name:

Credit Card #

CCV (3-digit code behind credit card):

Expiration date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing address associated with credit card: Zip code

I am agreeing to the terms and conditions set forth above.

Client/guardian signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_ Provider signature:­­­­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_­­­\_\_ ­­

I understand that if I decline this service, I will keep a zero balance by paying fees by check or cash at time of service or when fees are incurred.