THE PISGAH INSTITUTE *for* PSYCHOTHERAPY AND EDUCATION, P.A.
158 Zillicoa Street, Asheville, NC 28801 www.pisgahinstitute.com
Phone: (828) 254-9494 Fax: (828) 250-0890

Authorization to Charge Credit Card

Patient Name: _____ DOB: _____

Name on Credit Card: _____

Mailing Address of Credit Card: _____ _____ _____
CITY STATE ZIP

Phone Number of person whose name is on credit card: _____

Credit Card Number (last 4 digits): _____ Visa MC Discover Amex _____
Circle One Expiration Date

CVC2/CVV2 (3-digit security code on back of card): _____

I authorize The Pisgah Institute, P.A. to charge my credit card for _____'s office charges.
Patient name

I understand that if my credit card company 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 owing will be due and payable in full.

- Co-payments are due at the time of service. This is the **TOTAL** of what the insurance does not pay.
- Insurance policies are contracts between you and your insurance company. We file the claims as a courtesy and try to help with problems, but you will need to resolve those beyond our control. If insurance is not paying within a reasonable time, you will be responsible for the full payment.
- We will only file secondary insurance if we are a participating provider with that insurance company. If you have a secondary insurance that we are not a participating provider with, you must pay what your primary insurance does not cover.
- If your provider is not covered by your insurance company, full payment is due when services are provided.
- Phone consultations will be charged unless they are covered by insurance.
- There are charges for missed appointments and late cancellations. (Late cancellations are any appointments cancelled less than 24 hours prior to the appointment.)
- Prescription refills are charged $15 per prescription written, called in, or faxed outside of a scheduled appointment.

_____ _____
SIGNATURE DATE
(of person whose name is on credit card)

Updated 02/24/21

OFFICE USE ONLY – Patient ID# _____