SHEREEN MORSE, M.D.

PSYCHIATRY

1416 NW 46th St. #105, 222, Seattle, WA 98107
T (206) 353-1150 **F** (206) 632-2248

I, _____, agree to put my signature on file so that Dr. Shereen Morse or her chosen representative can charge my credit and/or bank card for services received and/or for fees incurred by not giving adequate notice of cancellation for a scheduled appointment.

I understand Dr. Shereen Morse's cancellation and no-show policy as they are written in her office policies and have clarified them with her today. Initial here→_____

If I decide to revoke this agreement, I, or an Authorized Agent*, will contact NW Clinical Billing at David@nwclincial.com or by phone at (360) 768-2168.

I understand that a payment agreement has been officially cancelled only after I have received confirmation from an associate at Northwest Clinical Billing.

I understand that said confirmation will not occur on weekends and/or during typically recognized holidays and that it can take several days for a revocation to be completed.

Should I decide to cancel this agreement, I agree to facilitate adequate correspondence by providing appropriate contact information to Northwest Clinical Billing and/or to Dr. Shereen Morse.

If I think I have been charged incorrectly, I will address this with Northwest Clinical Billing and/or Dr. Shereen Morse. If it is found that I have been incorrectly charged, I will be reimbursed those funds.

I understand that in order to store my card on file, the credit card processing company requires my email to be stored along side my credit card information. The email that I authorize for this use is as follows:

_____

Email Address

Credit card number _____-_____-_____-_____

Expiration date (MM/YY) _____/_____ CVV _____

_____

Patient's Name/ Date/Signature

_____

Authorized Agent's Name Relationship

*An Authorized Agent is an adult (+18) designated by the patient as a person's representative.