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PAYMENT AUTHORIZATION FORM

IPG requires all clients to store a valid credit/debit card on file with our Billing Department in order to reserve appointments. You will then elect to pay your fees by the card on file or through the patient portal.

Name of Patient: _____ Date of Birth: ____/____/____

Please indicate the card you wish to store on file, on our secure and encrypted server:

Name on Card: _____

Credit/Debit Card # _____ Expiration ____/____/____

Circle One: Visa MasterCard Discover AMEX CVV Code: _____

Billing Address of Card: _____ City _____

State: _____ Zip: _____ Mobile Number: _____

Email: _____

Please check ONE BOX below and sign at the bottom:

Always use Credit Card (Default if neither box is checked)

☐ I want all assigned fees, copays, coinsurance amounts, deductibles or any amounts due as determined by my insurance for the patient listed at the top of this page, to be charged to the card above.

OR

Patient Portal First, then Credit Card

☐ I want to pay all assigned fees, copays, coinsurance amounts, deductibles or any amounts due as determined by my insurance, for the patient listed at the top of this page, via the Patient Portal. Please do not charge my card stored on file until I have had the opportunity to make a payment in the patient portal. I understand that after **two weeks**, an unpaid invoice due may be charged to my card on file.

In **both** options, IPG reserves the right to use your card on file to pay:

- Any remaining copays or coinsurance amounts as specified by my insurance plan after successful processing of my claims.
- Deductible amounts which my insurance plan has, as determined after successful processing of my claim.
- Any Late Cancellation or Missed Appointment fees I have incurred.
- The amount my insurance reimburses me directly on an out-of-network basis for our sessions, if and when I have not forwarded that check or amount to IPG within two weeks of receipt.
- Bank fees or charges associated with bounced or returned checks.

By signing this payment authorization form, I certify that I am the cardholder and am authorized to agree to the above terms on behalf of the patient listed. I agree to the above terms.

_____ Date _____/_____/_____

Cardholder Signature