Insight Psychological Group David Helfgott, Psy.D. LLC
773 Central Avenue, Westfield, NJ 07090
240 W. Passaic St. Suite 10, Maywood NJ 07607
241 Cedar Lane, Suite 2A, Teaneck, NJ 07666

Tax ID: 46-5382812
26-3073176
NPI: 1598184780
Main Office: 908-228-2740

PAYING FOR TREATMENT AT INSIGHT PSYCHOLOGICAL GROUP

- Payment Authorization Form -

As of January 2021, IPG has switched to digital-only payment methods, even when treatment occurs in-person.

In order to reserve appointments with our therapists, IPG requires all clients to keep a valid credit/debit card stored on file with our Billing Department.

Each month, following the successful processing of your insurance claims, an invoice for your balance on services rendered will be sent to your Patient Portal (found at members.centralreach.com). You will have three weeks to review the charges and make a payment directly through the portal or to call our offices to make alternative payment arrangements.

Unless alternative arrangements are made, at the invoice due date any remaining balance on the invoice will be charged to the card you keep on file.

This form is for authorizing your card to be used to pay any remaining fees, copays, coinsurance or deductible amounts you owe.

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: _____

Authorization:

_____ (initial) I authorize the use of the above card to be charged all assigned copays, coinsurance amounts, deductibles, late cancellation or no-show fees, or any amounts due as determined by my insurance, which I have not paid myself in my Patient Portal, for the patient listed at the top of this page. If no insurance is used, I agree to pay IPG's regular fees, unless explicitly agreed to by IPG in advance of my treatment.

IPG also reserves the right to use your card on file to pay:

- 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 authorized to agree to the above terms on behalf of the patient listed. I agree to the above terms.

_____ _____ Date _____/_____/_____

Signed Name Printed Name