Insight Psychological Group David Helfgott, Psy.D. LLC
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PAYING FOR TREATMENT AT INSIGHT PSYCHOLOGICAL GROUP

- Payment Authorization Form -

IPG processes payments using only cashless, electronic methods, even when treatment occurs in-person. As such, in order to reserve appointments with our therapists, IPG requires all clients to keep a valid credit/debit card securely stored on file with our Billing Department.

Therapy is a weekly process, which is continuously billed to you or to your insurance, generating ongoing cost-sharing balances. To keep this process as smooth as possible, our Billing Department seamlessly charges your monthly balance of copays or other insurance-sharing costs to your credit/debit card securely kept on file. You will not need to log-in to pay or manually mail checks.

You will always be able to see and review your charges in advance: 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 where you can review it or pay it yourself. If you have questions or would like to make alternative payment arrangements, that would be the time to do it. After the due date listed on your invoice, our Billing Office will go ahead and charge the card on file and balance due, unless otherwise arranged.

This form is for authorizing your card to be used to pay any balance of 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:

With my signature below, I authorize the use of the above card to be charged all assigned copays, coinsurance amounts, deductibles, Scheduling fees for appointments not kept, 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.

I understand that IPG also reserves the right to use my 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