Integrative Psychological Services, LLC

Credit Card Policy

Client Name: ______________________________________

At Integrative Psychological Services, LLC we request a credit card be kept on file to be used as a method of payment for sessions (for out-of-network clients) or balances not covered by your insurance plan and any differences resulting from the amount billed and the amount covered (e.g., copays, deductibles). By signing this credit card authorization you are allowing us to charge any balance due on the date of service and/or a balance that is past due 30 days.

Type of Credit Card (Please Circle): VISA MASTERCARD DISCOVER AMERICAN EXPRESS

Name on credit card (exactly as it appears on card):

____

Billing Address (including zip code):

____

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Phone Number: ____

Credit Card Number:

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Expiration Date:

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CVV Number on the back of the card:

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I authorize Integrative Psychological Services, LLC to charge my credit card for services provided. I also understand that I may continue to pay on a weekly basis by check or cash if I prefer. I understand that IPS will keep my credit card information on file and that it will be kept confidential and secure.

____ ____________________________

Signature **Date**

Updated 11/16/18