INSTITUTE FOR
PRACTICAL LIFE
"your place for psychotherapy and wellness"

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CREDIT CARD AUTHORIZATION FORM

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Patient name:.....

Last name:.....

CREDIT CARD INFORMATION

Card type: ☐ MASTERCARD ☐ VISA ☐ DISCOVER ☐ AMERICAN EXPRESS ☐ OTHER:.....

Name on the card:.....

Account number:.....

Security code:..... Expiration date:...../...../.....

Billing address:.....

Apto:..... City:..... State:..... Zip:.....

Email address:.....

AGREEMENT TO PAY

I understand that I am financially responsible to IPL (Institute for Practical Life) for services rendered. I agree to pay the copay, coinsurance and any deductibles stipulated by my insurance plan. Payment is due at the time of my appointment. It is my responsibility to inform the IPL of any changes that affect the billing or charges to my account. This includes changes in any of my third-party payers, income or family status. I understand that standard collection procedures will be followed if payment is not made.

First name:.....

Last name:.....

Date:.....

Signature:.....