United Psychological
SERVICES

Credit Card Signature On File Authorization Form

All credit card information will remain confidential and will not be released to any unauthorized party.

We have implemented a policy which maintains credit card information securely on file with Instamed. You will be asked for a credit card at the time you check-in.

By providing United Psychological Services with your credit card information, you are giving United Psychological Services permission to automatically charge your credit card on file to pay co-pays, deductibles and balances you owe after your insurance company has paid their portion and notified us of the amount that is your responsibility. You will receive a statement that will indicate the amount due and we will deduct that amount from your card 7-10 days later. This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment.

I hereby authorize United Psychological Services to charge the credit card provided on file with Instamed on behalf of United Psychological Services on an as needed basis for the amount(s) due for service(s) that are the patient responsibility amount as determined by insurance. I further authorize that any time my account becomes past due United Psychological Services may use this card to settle the debts owed on my behalf. Any overpayments on my account will be credited back to my card. My credit card statement will serve as a receipt for payments that have been processed. I may request a copy of my receipt by contacting United Psychological Services at (586) 323-3620 and a response will be sent to me via email.

This document designates my Signature is on File and therefore is not required that I sign paper receipts each time my credit card is processed. This authorization is to remain in effect until United Psychological Services receives written notification from me of its termination. If my credit card information listed below changes for any reason, I will notify the billing department at United Psychological Services as soon as possible.

_____ Date of Birth _____

(Signature) Date

This credit card will be on file for dependent(s), please print name(s) below:

Patient Full Name: _____ Patient Full Name: _____

Patient Full Name: _____ Patient Full Name: _____

If you think your charges are incorrect, please contact the billing department at United Psychological Services with an explanation of the problem. We will make any necessary adjustments to your account within 30 days. After 60 days all charges will be assumed to be correct. Contact information: (586) 323-3620

Mailing Address:
United Psychological Services
47818 Van Dyke Ave., Shelby Township, MI 48317
Attention: Billing Department