Caroljean Bongo, Psy.D., LLC

Authorization to Secure Payment

If I am using insurance to pay for services provided by Caroljean Bongo PsyD, I understand that Dr. Bongo is billing my insurance company as a courtesy to me rather than my paying for services up front and waiting to be reimbursed by my insurance company. Dr. Bongo utilizes Psychiatric Billing Associates to process my insurance claims. Dr. Bongo and Psychiatric Billing Associates will work with me and my insurance company to receive payment.

I understand that I am responsible for all reasonable and customary fees that my insurance company does not pay, such as deductibles, co-pays and amounts deemed as non-billable or uncovered services.

I, _____ authorize Caroljean Bongo, PsyD, LLC, and Psychiatric Billing Associates to process payment on my Visa, MasterCard, Discover or Health Savings Account card for services and/or any balance due that has not been paid **30 days after it is mailed.** If I prefer not to pay with my credit card, I will call Psychiatric Billing Associates (800-650-6334 EXT: 33 - Kathy) to make other arrangements for payment, prior to the passing of 30 days of mailing of your initial billing statement.

If I chose to pay my balance due or make payments with the below listed payment source, this information will be entered into the InstaMed payment portal system. If the card information provided below is utilized as a guaranteed payment, I understand the information I provided will be entered into the InstaMed payment system.

I understand that I have given Caroljean Bongo PsyD, LLC, debit/credit card information. I understand the intended uses for this form include payment and guarantee of payment.
I hereby authorize Caroljean Bongo, PsyD, LLC, to process payment on my Visa, MasterCard, Discover or Health Savings Account cards:

[ ] automatically for any balance due. I understand I will receive a complete receipt for any services charged to my card.
[ ] I authorize my credit card to be charged only if I have not paid my balance within **30 days of the statement date.** I understand that I will receive a complete receipt for any services charged to my card.

I have read and understand this form. I attest that the information below is true and accurate.

My credit card information is as follows:

_____
Signature of Card Holder

_____ _____
Cardholder's Name Client's Name

_____ _____ _____
Credit Card Account Number Expiration Date Security Code
Is this a debit card?
☐ Yes ☐ No

_____
Today's Date

Billing address: _____

Amount to be deducted: _____

E-Mail Address_____
The above mentioned charges on your card will appear from **Caroljean Bongo PsyD LLC.