For office use only:

CLIENT NAME_____ Date received in office:_____ Date DC'ed:_____

PAYMENT INFORMATION FORM

Insight Therapeutics, Inc. offers credit/debit card payment processing through Square POS, an encrypted mobile card reader system that is integrated with the billing system for Insight Therapeutics, Inc. Square POS houses payment data on servers with a minimum of 128 bit encrypted security keys with extended validation SSL certificates. While your provider may swipe your credit card on what appears to be their personal cell phone, tablet or computer, you can rest assured that **NO CARD INFORMATION IS STORED ON THE PHYSICAL DEVICE USED FOR PAYMENT**. Instead, payment data is stored on Square POS's servers, an account that is only accessible to Insight's billing staff. If you would like more information about Square POS and their security policies, please review their website at www.squareup.com.

If you have the same debit/credit card, Flexible Spending Account (FSA), or Health Savings Account (HSA) card you would like to use for payment of services, you are welcome to keep this information on file with Insight Therapeutics, Inc. **At the time of session we will always ask for the physical card, as this is always more secure than running your card manually later**. This form is kept as part of your client billing file, and will NEVER be released to a third party unless we are legally obligated to do so. If you opt to bill payments for an appointment to a credit card number on file, your clinician will write "CC on File" on your super bill. **We assume that the funds are available on the stored card that day unless you tell us otherwise**. If they are not, your clinician will contact you to alert you that the card has been declined. We ask that you then make prompt payment arrangements with your therapist, and you may be required to bring a card to session in the future rather than store a card on file. Please note that missed appointment fees are NOT able to be paid with an HSA or FSA card. **Charges that may be reversed or declined by the credit card company for any reason remain the responsibility of the client/guarantor for payment**.

Card Company (Check one): ☐Visa ☐MasterCard ☐Discover ☐American Express

Card Type (Check one): ☐Credit ☐Debit ☐Health Savings Account (HSA) ☐Flexible Spending Account (FSA)

Name on Card (Print Clearly):_____

Card Billing Address:_____

City: _____ **State**: _____ **ZIP**:_____

Card Number:_____

Card Expiration Date: _____ **Card CCV Code** _____(3 digit number on back of card. For American Express, 4 digit number above the card number on front)

DIGITAL RECEIPT FORMAT (Check one and complete):

☐Email Receipt to: _____ ☐Text Receipt to: _____

☐No digital receipt needed, I will keep the receipt provided at the time of session as my payment record.

My signature authorizes Insight Therapeutics, Inc. to charge the credit card account listed for services rendered. By signing below I acknowledge that I am legally able to authorize payments for the above listed credit card. I understand that Insight Therapeutics, Inc. will communicate the amount to be charged prior to charging unless other arrangements have been made. I have read, understand, and agree to the Financial Policy and Payment Information Form for Insight Therapeutics.

Client Signature (Age 12 and older):_____

Parent/Guardian and/or Cardholder Signature: _____