Healthy Wings, LLC
2055 East Southern Ave., Ste B, Tempe, AZ 85282-7507

CREDIT CARD ON FILE AUTHORIZATION

Information to be completed by Cardholder:

The undersigned agrees and authorizes Healthy Wings, LLC, d/b/a Healthy Wings Family & Psychiatric Healthcare, and/or it's third-party billing company (i.e., Headway, Alma) (herein referred to as "HWLLC"), to save the credit/debit card on file as entered into this document and/or into my electronic health record.

I authorize HWLLC to process the credit card as "Card on File". I understand this authorization will remain in effect until the expiration of the credit/debit card account, at which point, it will be updated with a valid credit/debit card. Patients may also revoke this form by submitting a written request to HWLLC at the address above. If a charge is processed to the card on file and is declined, the Patient will be billed for any fee(s) associated with the decline of the card.

I understand that if the invoice sent to me prior to my appointment is not paid at least 24-hours prior to the appointment, HWLLC will charge the amount due to my card on file.

I further understand that if there is a balance due after my insurance benefits has paid for my visit, my card on file will be charged for the balance without prior notification. This is not "balance billing," as the balance due would be considered the patient's responsibility as noted in your Explanation of Benefits (EOB) provided by your insurance company.

I acknowledge that I am an authorized user of the card being used, or I have been given permission to utilize such card. If a fraudulent accusation results from the use of this card, HWLLC will cooperate with the authorities to prosecute any illegal activity. Please make sure you have the permission of the cardholder to use the credit/debit card on file.

Patient's Printed Name: _____

Patient's Legal Representative's Name: _____ Birth Date: _____

Name as it Appears on the Credit/Debit Card: _____

Type of Credit Card: ☐ MasterCard ☐ Visa ☐ Discover ☐ Amex

Card #:

Expiration Date:

Security Code (CVV):

Full Billing Address: _____

City, State, Zip Code: _____

Patient's Signature: _____

OFFICE USE: Recorded By: _____ Date/Time Recorded: _____ Rev: 12/2022