



Credit card authorization

I understand that Harmony Heaven Psychiatry is a cashless/paperless practice and that all co-pays, deductible and coinsurance amounts will need to be charged to my credit card. Harmony Heaven Psychiatry is asking that all patients provide a credit card verbally to billing staff which will be stored in the Bill Flash HIPAA compliant billing software utilized by Harmony Heaven. I understand that the credit card on file will be charged to cover any and all fees not covered by the patient's health insurance plan (See financial agreement for more details). I acknowledge that this authorization shall remain in effect until I request that it be cancelled, or am discharged from Harmony Heaven Psychiatry. I certify that I am the authorized user of the Credit Card that I will be providing to Harmony Heaven Psychiatry. As long as the transactions correspond to the terms and conditions indicated in this authorization, I shall not raise disputes against Harmony Heaven Psychiatry or affiliated providers. Additionally, I understand that it is my responsibility to notify the office should my credit card information change. Credit Card Information

I understand Harmony Heaven Psychiatry's billing procedures and agree to provide the office with a credit card which will be kept on file to cover expenses related to my mental health treatment that are not covered by my health insurance. _____

Signature of the Patient or Responsible Party

Date