



HUMMINGBIRD HEALTH & WELLNESS

1015 E Broad Street, Ste 112

Columbus, Ohio 43205

P: 614-285-6562

E: info@hummingbirdhealthohio.com

Authorization for Credit Card on File

Patient Name: _____

Date of Birth: _____

Cardholder Name (if different from patient): _____

Last 4 Digits of Credit/Debit Card: ____ ____ ____ ____

Authorization

I authorize Mente Sana, LLC DBA Hummingbird Health & Wellness to securely keep my credit or debit card information on file.

I understand that Mente Sana, LLC DBA Hummingbird Health & Wellness will bill my insurance carrier first, if applicable. After my insurance has processed the claim and determined my responsibility, I authorize Mente Sana, LLC DBA Hummingbird Health & Wellness to charge my credit card only for amounts for which I am financially responsible.

These charges may include, but are not limited to:

- Missed, late-canceled, or no-show appointments in accordance with the practice's cancellation policy
- Co-payments due at the time of service
- Deductible and/or co-insurance amounts after insurance processing
- Charges for services not covered, denied, or determined to be patient responsibility

I understand that my credit card will not be charged for services covered by insurance.

Acknowledgment & Consent

I certify that I am the authorized cardholder or have authorization from the cardholder to provide this consent. I understand that I may revoke this authorization at any time by providing written notice to Mente Sana, LLC DBA Hummingbird Health & Wellness subject to any outstanding balances.

Patient Name (Please Print)

Patient Signature

Date

If signed by a legal representative:

Name (Please Print)

Relationship to Patient