

HealthWare Inc.
Credit Card or Checking Account Agreement Form

The undersigned hereby agrees and authorizes HealthWare Inc. to keep my signature on file and to charge the bankcard account identified below for all amounts due to HealthWare Inc. for electronic claims submission. Debits will be made on approximately the 1st of each month.

PLEASE CIRCLE ONE: VISA MASTERCARD CHECKING ACCOUNT DEBIT
(If above attach blank voided check)

CREDIT CARD ACCT# _____ EXP. DATE ____/____

Name (as it appears on card) _____ (Please Print)

Credit Card billing Zip Code. _____

I agree to submit my claims through software provided to me by HealthWare Inc. I hereby appoint HealthWare Inc. to be my agent when necessary for the submission of our claims. I will pay HealthWare Inc, \$.30 per claim for all claims submitted. HealthWare Inc. makes no warranty, expressed or implied for its services hereunder. I understand that if HealthWare Inc. makes any error that causes a claim to be rejected, the error will be corrected and the claim will be resubmitted to the payor at no additional charge to me.

Signature _____ Date _____

HealthWare Inc. – P.O. BOX 71663 Madison Heights, MI 48071
Phone (866)332-5849 Fax (248)733-9989