HILLSIDE

ONE TIME CREDIT CARD AUTHORIZATION

I hereby authorize Hillside, Inc. to charge my credit card as indicated below for services provided by Hillside, Inc.:

Amount: **$** _____ **Patient Name /Account #** _____

Description: _____

Billing Information:

Title: ____ First Name*: _____ MI: ___ Last Name*: _____

Street 1*: _____

Street 2: _____

City*: _____

State*: _____

ZIP Code*: _____

Phone Number: (___) _____

Email Address*: _____

Method of Payment:

Credit Card: ___ Amex ___ Visa ___ MasterCard ___ Discover

Credit Card #: _____ Expiration: ___/___ CVV Number: _____

Authorized Signature: _____ Date: _____

PLEASE COMPLETE THIS AUTHORIZATION FORM AND RETURN TO:

Hillside, Inc.
Attn: Accounts Receivable
690 Courtenay Dr. NE
Atlanta, GA 30306

Fax: 404-875-8090 Attn: Accounts Receivable
E-mail: rsouthworth@hside.org

* Required Fields