HILLSIDE

RECURRING CREDIT CARD AUTHORIZATION

I, _____, hereby authorize you to charge my credit card for Deductibles and Co-Payments on services provided by Hillside, Inc. as part of the treatment of _____, without further authorization or notification. Hillside will provide an invoice for all services billed at the end of each month. I understand that my credit card will be charged for amounts in addition to the following estimates if my insurance does not cover remaining charges:

Individual Therapy Session	☐ **$** _____	☐ **Co-Pay**	☐ **Self-Pay**
Family Therapy Session	☐ **$** _____	☐ **Co-Pay**	☐ **Self-Pay**
DBT Skills Group Session	☐ **$** _____	☐ **Co-Pay**	☐ **Self-Pay**
Other: _____	☐ **$** _____	☐ **Co-Pay**	☐ **Self-Pay**

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