



# 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