HILLSIDE

RECURRING CREDIT CARD AUTHORIZATION [Residential / PHP Program]

I, _____, hereby authorize Hillside, Inc. to charge my credit card for Deductibles, Co-Payments, and Co-Insurance and Self-Pay amounts 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 all amounts that my insurance does not cover.

_____ **Partial Hospitalization / Day **** ☐ **$** _____ ☐ **Self-Pay**

_____ **PRTF per Day **** ☐ **$** _____ ☐ **Self-Pay**

_____ **PRTF Room & Board / Day **** ☐ **$** _____ ☐ **Self-Pay**

_____ **Pharmacy** ☐ **Any amounts not covered by my insurance.**

_____ **Deductible [Estimate]** ☐ **$ Maximum** _____

_____ **Co-Insurance [Estimate]** ☐ **$ Maximum** _____ **%** _____

_____ **Other** _____

Billing Information:

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

Street 1*: _____

Street 2: _____

City*: _____ State*: _____ ZIP Code*: _____

Phone Number: (___) _____ E-Mail 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

_____ ** After the initial deposit on admission, estimated charges for the following month will be charged on approximately the first day of each month, without notification. Any unused amounts will be refunded once all insurance claims have processed.