HILLCREST
COMPREHENSIVE
PSYCHOLOGICAL SERVICES

Phone: 803-569-3101
www.hillcrestcps.co

Credit Card Authorization

Hillcrest is committed to providing you with exceptional care, as well as maintaining a simple and efficient billing process. To provide a seamless, convenient way for patients to pay their bills, Hillcrest requires all patients keep an active credit card on file with us.

By signing this form, you give Hillcrest permission to charge your card for the amount required for: self-pay, copays, missed appointments, late cancellations and/or deductibles at the times of your sessions. An active credit or debit card must be on file or a $99.00 cash deposit will be necessary to see a clinician. If you have any questions about this payment method, do not hesitate to ask.

I, _____, authorize Hillcrest to charge my debit/credit card account for any deductibles or copays that may apply at my time(s) of service, including a $99.00 fee for missed appointments. ** Be sure to cancel appointments 24 hours in advance to avoid fees. **

Cardholder Information

Name (as it appears on your card): _____

Billing address: _____

City:_____State:_____Zip code: _____

Primary phone number:_____email:_____

Visa: _____ Mastercard: _____ Discover: _____ Debit: _____

Card number: _____ – _____ –_____ – _____

Expiration date: _____ / _____ Security Code (back of card): _____

I authorize the Hillcrest to charge the credit/debit card indicated in this authorization form according to the terms outlined above. Payment authorization is for the services described and is valid for all sessions that require payments at the time of service. I certify that I am an authorized user on this debit/credit card. I will not dispute the payment with my debit/credit card company so long as the transactions correspond to the terms indicated in this form.

Signature: _____Date:_____