



Seven Hills Psychology, LLC

CREDIT CARD BILLING FORM

Credit Card Information

Name on Credit Card: _____ Type: Visa ___ MC ___ Disc ___ AmEx ___

Account Number: _____ Exp Date: _____ Security Code: _____

Billing Zip Code: _____ Phone Number: _____

I understand that my credit card will be charged for all outstanding balances not covered by my insurance. These charges include co-payments, co-insurances, deductibles, missed session/late cancellation fees, and any other charges outlined in the "Client Information and Acknowledgment of Informed Consent to Treatment" document.

Signature of Account Holder

Printed Name

Date