Richard R Hill MD PhD
19910 Malvern Road
Suite 223
Shaker Heights, Ohio 44122
(216) 309-1550

As per treatment agreement, a credit card on file will be needed to render services . I authorize RICHARD R HILL MD PhD to charge the credit card automatically after each service is provided (including no-show appointments) as indicated in the signed treatment agreement.

CARDHOLDER INFORMATION

Name of Patient:_____

Cardholder Name:_____

Address:_____

CARD INFORMATION

Credit Card: _____–_____–_____ –_____

Security Code:_____

Expiration : _____/_____

___ Am Ex ___ MC ___ Visa ___ Health Savings Card __Debit / Other

_____ _____

Cardholders Authorized Signature Date