Heather Hopper, Ph.D.
2200 Century Parkway, Suite 200
Atlanta GA 30345
404-631-6310 (p) 404-325-3663 (f)

Credit Card Charge Form

I agree to allow Dr. Heather Hopper to charge my credit card, information noted below

for the following services: _____

for the following person: _____

under the following conditions:

Not to exceed $_____ per visit plus all fees not covered by insurance within 90 days.

(Copays are usually $ _____, for a 45 minute session, but may be higher or lower for other services)

When sessions are missed will charge full agreed on rate for scheduled service. (This is $_____ for a 45 minute session, but may be higher or lower depending on the scheduled service.)

Type of Card: American Express MasterCard Visa Discover

Card Number _____

Expiration Date _____ CVV number _____

Billing Address (including number, street, apt/suite, city, state, and zip code)

_____

Name (as printed on card) _____

Signed _____ Date: _____

This agreement expires on _____ (date) or within one calendar year, whichever is earlier.