

# Thrive Girls Academy Intake Application

Submitted By: \_\_\_\_\_

Date: \_\_\_\_\_

## Client Information

Name: \_\_\_\_\_

First Middle Last

Gender at Birth: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

SSN : \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Mobile : \_\_\_\_\_

Email : \_\_\_\_\_

Expect to Enroll: \_\_\_\_\_

School Grade: \_\_\_\_\_

### Emergency Contact (other than Parent/Guardian):

Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Mobile : \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Type of Plan: **Initial** Estimated Length of Stay in Placement: Program Length 12 monthsCurrent Level of Care: **Basic** Effective Date of Plan: \_\_\_\_\_ Legal Status of Child: TMC

## Parent/Guardian/Sponsor Information

Parent/Guardian/Sponsor: (PRIMARY): \_\_\_\_\_

Please mark all that apply: Parent  Guardian  Legal Custody  Physical Custody  Sponsor  Adoption 

Relationship: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN : \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Method of contact : \_\_\_\_\_ Home Phone : \_\_\_\_\_ Mobile : \_\_\_\_\_ Home Fax : \_\_\_\_\_

Home Email : \_\_\_\_\_ Job title : \_\_\_\_\_ Work Phone : \_\_\_\_\_

Employer : \_\_\_\_\_ Work Email : \_\_\_\_\_ Work Fax : \_\_\_\_\_

Parent/Guardian/Sponsor: (SECONDARY): \_\_\_\_\_

Please mark all that apply: Parent  Guardian  Legal Custody  Physical Custody  Sponsor  Adoption 

Relationship: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN : \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Method of contact : \_\_\_\_\_ Home Phone : \_\_\_\_\_ Mobile : \_\_\_\_\_ Home Fax : \_\_\_\_\_

Home Email : \_\_\_\_\_ Job title : \_\_\_\_\_ Work Phone : \_\_\_\_\_

Employer : \_\_\_\_\_ Work Email : \_\_\_\_\_ Work Fax : \_\_\_\_\_

Briefly describe relationships and home environment between the above persons and applicant \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**General Information**

Is the applicant fluent in any languages other than English?: \_\_\_\_\_ Specify: \_\_\_\_\_

Child's Ethnicity:  Hispanic  Other Hair Color: \_\_\_\_\_ Eye: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 Legal status: US Citizen Yes No Other: \_\_\_\_\_

Child's Race: (Check one)	White <input type="checkbox"/>	Black <input type="checkbox"/>	Asian <input type="checkbox"/>	American Indian/Alaskan Native <input type="checkbox"/>	Native Hawaiian/Pacific Islander <input type="checkbox"/>	Unable to Determine <input type="checkbox"/>
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**Parent/Guardian Report**

Please describe your reasons for wanting to place your child at THRIVE Girls Academy and behaviors:

\_\_\_\_\_

\_\_\_\_\_

Comment on any factors that may have contributed to the problems that your child is having: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please describe what steps you have taken so far to help your child: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Briefly Describe your child's strength, special skills and interests, talents and personality: \_\_\_\_\_

Briefly Describe your child's triggers:

\_\_\_\_\_

\_\_\_\_\_

Has the applicant been raised by anyone other than her parents: Please explain : \_\_\_\_\_

Does the child have siblings: Yes or No                      If Yes, are they in substitute care: Yes or No

If the child has siblings in care that are placed separately, identify placing Agency or Kinship Family Name:

\_\_\_\_\_

Type of contact approved (such as: letters, email, skype, phone, cell, text) \_\_\_\_\_ If  
 visitation or contact is not allowed explain why: \_\_\_\_\_

Efforts to maintain and improve connections with family and other caring adults:

\_\_\_\_\_

Summary of visitation of contacts (Discuss how visits are going, how often they are occurring, and any barriers to visitation: \_\_\_\_\_

Identified goals for visits (discuss goals which have been identified such as improve or re-establish relationships improve sibling connections, etc.): \_\_\_\_\_

Identified needs and plans to address (discuss any issues related to ensuring visitation occurs and what is being done to overcome as well as any other issues that need to be addressed regarding visitation):

\_\_\_\_\_

\_\_\_\_\_

Has there been a death of a friend or relative in the past year? \_\_\_\_\_ Please explain: \_\_\_\_\_

\_\_\_\_\_

Has there been a divorce in the family: \_\_\_\_\_

*A copy of the divorce decree and custody arrangements will need to be submitted to Teen Challenge with these forms.*

Please describe the divorce dynamics that may have had an impact on your child: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Is there a separation or divorce pending: \_\_\_\_\_ Are you currently married? \_\_\_\_\_

Please describe the conditions of your current marriage: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Legal History**

Has the student ever been arrested: \_\_\_\_\_ Describe any history or current juvenile justice involvement:

Please give number of, dates of, city and state, reason for and disposition of arrest(s):

Charges	Adjudication Status

Please provide any pertinent details: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

Pending charges : \_\_\_\_\_

Charge : \_\_\_\_\_

Court Date: \_\_\_\_\_ Has the student ever been convicted : \_\_\_\_\_

Please provide details: \_\_\_\_\_

Is the student under a FINS petition: \_\_\_\_\_

Is the student on probation: \_\_\_\_\_ Probation Officer Name: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Phone : \_\_\_\_\_ Ext.: \_\_\_\_\_ Cell: \_\_\_\_\_

Email: \_\_\_\_\_

Please provide information about any other illegal activity that you feel THRIVE Girls Academy should know about your daughter: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

Does your child have a history of using/abusing over•the•counter substances: \_\_\_\_\_

Please explain: \_\_\_\_\_

**Insurance Information**

**Primary Insurance Company:** \_\_\_\_\_ **Address:** \_\_\_\_\_

Benefits Phone: \_\_\_\_\_ Group Number: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Policyholder's Name: \_\_\_\_\_

Employer: \_\_\_\_\_ Date of Birth : \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Rx BIN #: \_\_\_\_\_ Rx PCN #: \_\_\_\_\_ Pharmacy Help Desk Phone: \_\_\_\_\_

**Secondary Insurance Company:** \_\_\_\_\_ **Address:** \_\_\_\_\_

Benefits Phone: \_\_\_\_\_ Group Number: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Policyholder's Name: \_\_\_\_\_

Employer: \_\_\_\_\_ Date of Birth : \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Rx BIN #: \_\_\_\_\_ Rx PCN #: \_\_\_\_\_ Pharmacy Help Desk Phone: \_\_\_\_\_

Please list **current information** for your daughters Psychiatrist in Texas:

Psychiatrist Name	Location	Phone	Date Last seen	Email address

If you live **outside** of Texas, please list Psychiatrist in Texas that your medical insurance covers:

Psychiatrist Name	Location	Phone	Date Last seen	Email address

**Current Medications** Please list ALL medications below,;

Current medications, non-psychotropic & psychotropic medication including over the counter and supplements.

Medication Name	Dose & Frequency	Length of Time	Prescribing Physician	Reason Prescribed/Taking	Do you believe the medication is effective?	Prescribing Physician and contact information

Describe any side effect experienced by the child:

List of Psychotropic Medication Name	Dose & Frequency	Length of Time	Prescribing Physician	Reason Prescribed/Taking	Do you believe the medication is effective?	Prescribing Physician and contact information

Describe any side effect experienced by the child:

List DME supplies: \_\_\_\_\_ Is there a DNR? Yes or No

**Medical History**

Pregnancy and Early Development

Illness or Complications? ( ) Yes ( ) No

C-section? ( ) Yes ( ) No

Smoking During Pregnancy? ( ) Yes ( ) No

Alcohol? ( ) Yes ( ) No

Drugs/Medications? ( ) Yes ( ) No

Premature Delivery? ( ) Yes ( ) No

If so, length of hospitalization \_\_\_\_\_

**Treatment / Placement History**

*Please include all previous counseling, inpatient, psychiatric, psychological, or any other professional services received:*

Dates - List Recent admission	Dates - List Recent discharge	Agency or Program	Reason for Treatment/Placement	Results of Placement/Treatment

Parent/Guardian Must provide initial evaluation of appropriate placement & ensure that necessary information for service planning is provided with this application for enrollment consideration.

**PRE-ASSESSMENT SCREENING** Checked by Office Staff (Name): \_\_\_\_\_

Check all that apply to your daughter's current and past diagnosis (provide diagnosis documentation):

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> ADHD                            | <input type="checkbox"/> Heart Dysfunction        | <input type="checkbox"/> Hepatitis         |
| <input type="checkbox"/> dental problems                 | <input type="checkbox"/> Vision problems          | <input type="checkbox"/> Nervous Condition |
| <input type="checkbox"/> Allergies/Asthma                | <input type="checkbox"/> Back Problems            | <input type="checkbox"/> Liver Dysfunction |
| <input type="checkbox"/> Trauma                          | <input type="checkbox"/> HIV                      | <input type="checkbox"/> Diabetes          |
| <input type="checkbox"/> Seizures                        | <input type="checkbox"/> Blood Disorder           | <input type="checkbox"/> Autism            |
| <input type="checkbox"/> Lung Dysfunction                | <input type="checkbox"/> Skin Infections          | <input type="checkbox"/> Anxiety           |
| <input type="checkbox"/> Sexually Transmitted Disease(s) | <input type="checkbox"/> Infectious Disease(s)    | Other: _____                               |
| <input type="checkbox"/> Bruises Easily                  | <input type="checkbox"/> Chronic Medical Problems |  |

Please provide details about all items indicated above: \_\_\_\_\_

\*Description of Allergies: \_\_\_\_\_  
 \_\_\_\_\_

Is your child able to participate in rigorous physical activities (i.e. sports, rappelling, hiking, running, etc.): \_\_\_\_\_

If not, please explain: \_\_\_\_\_

List any medical strengths: \_\_\_\_\_  
 \_\_\_\_\_

Date of last annual medical exam: \_\_\_\_\_ Next scheduled due date: \_\_\_\_\_

Date of last annual dental exam: \_\_\_\_\_ Date of last annual vision exam: \_\_\_\_\_

Date of last annual hearing exam: \_\_\_\_\_

Next scheduled dental exam: \_\_\_\_\_ Date of next scheduled vision exam: \_\_\_\_\_

Date of next scheduled hearing exam: \_\_\_\_\_

(Include results of the medical and dental exams)

Name of Clinical Professional: \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Name of Clinical Professional: \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

**\*\* Vaccine Preventable Disease Policy:** Once this students application is approved for enrollment a Copy of her Immunization shot records or an Affidavit Exemption from Immunizations for Reasons of Conscience must be emailed, faxed or mailed prior to admissions into ATCOT Thrive Girls Academy.

Please list all Hospitalizations and/or ER Visits:

Treated For:	Date[s]	Length of Stay	Place of Service/City/State

What is your religious/denominational preference: \_\_\_\_\_

Name of church and how often you attend on average: \_\_\_\_\_

Does your family attend church regularly, or are faith observant: \_\_\_\_\_

## ATCOT THRIVE GIRLS ACADEMY ADMISSIONS INFORMATION

### Referral Information

How did you first hear about Thrive Girls Academy?: \_\_\_\_\_

### Family Information

*Please provide the following. Do not include extended family (i.e. grandparents or aunts and uncles) unless that Family member has had guardianship or care of the child in the past. Please include adult children who live separately and parents that the child does not live with.*

Name	Relationship to Student	Age	Household Status	Substance User	Mental Health Issues	Allowed Contact

**Allowed Contacts:** Students may receive correspondence from immediate family, pastors, teachers, and/or counselors. Please let us know who you would like your child to receive mail, letters from. After 6 weeks in care/completion of Phase 1 students may receive scheduled phone call, text, Phase 2 family visit. Progress in program is reviewed before scheduling family visits.

Name	Relationship	Address	Phone number

Are there family members that should **not** have contact with your child, explain reason:

Name	Relationship	Address	Phone number
1.			
2.			
3.			
4.			
5.			

Explain reason for NO contact:

List all family and supportive adult relationships:

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Behavior Assessment

- Drug Abuse Explain: \_\_\_\_\_
- Running Away Explain: \_\_\_\_\_
- Physical Abuse Explain: \_\_\_\_\_
- Alcohol Abuse Explain: \_\_\_\_\_
- Aggressive/Violent Behavior Explain: \_\_\_\_\_
- Death of Loved One Explain: \_\_\_\_\_
- Tobacco/Vaping Explain: \_\_\_\_\_
- Abandonment Explain: \_\_\_\_\_
- Emotional Stress Explain: \_\_\_\_\_
- Emotional/bullied Abuse Explain: \_\_\_\_\_
- Anger Explain: \_\_\_\_\_
- Fear Explain: \_\_\_\_\_
- Family Relationships Explain: \_\_\_\_\_
- Arson/Fire Starting Explain: \_\_\_\_\_
- Sexual Abuse Explain: \_\_\_\_\_
- Self Mutilation/Cutting Explain: \_\_\_\_\_
- Pornography Explain: \_\_\_\_\_
- Insomnia Explain: \_\_\_\_\_
- Forgiveness Explain: \_\_\_\_\_
- Guilt Explain: \_\_\_\_\_
- Self Image Explain: \_\_\_\_\_
- Hearing Voices Explain: \_\_\_\_\_
- Hallucinations Explain: \_\_\_\_\_
- Paranoia Explain: \_\_\_\_\_
- Neglect Explain: \_\_\_\_\_
- Other Explain: \_\_\_\_\_
- Self-Harm: Has your child ever attempted suicide or had suicidal thoughts: YES or NO

When (Dates Suicide) \_\_\_\_\_ Number of attempts: \_\_\_\_\_

When (Dates Suicidal thoughts) \_\_\_\_\_ When (dates cutting) \_\_\_\_\_

Is your child currently suicidal: \_\_\_\_\_ Please explain: \_\_\_\_\_

If your daughter is accepted/enrolled into Thrive Girl Academy and begins to self-harm and is taken to a Behavioral Health Hospital for evaluation she will not be admitted back into the program. Parents will need to contact Campus Director or Campus Coordinator.

Has someone died by suicide, particularly a family member, friend, peer, or hero that your child is connected to?

Please explain: \_\_\_\_\_

Has your child ever been charged with a sexual offense: \_\_\_\_\_ Please explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_



**Substance Abuse History**

Please indicate any and all substances that you know your daughter has used.

Be sure to include all prescription drug abuse.

Substance	Current Usage Past 30 Days	If yes, pattern of use last 30 days (include amount and frequency)	Age of 1st Use	Age this became a problem?	Pattern of use for at least last 6 months (include amount and frequency)	Primary Route	Date, Time, and amount
Alcohol							
Amphetamines							
Barbiturates							
Crack							
Cocaine							
Ecstasy							
Heroin							
Huffing/Snuffing							
LSD							
Marijuana							
Methadone							
Methamphetamine							
Morphine							
Mushrooms							
Opioids							
Oxycontin							
PCP							
Tobacco							
Vape							
Fentanyl							
Other							

**Medical & Developmental History**

Were any of the following present during child's early childhood? Please circle below the appropriate:

\_\_\_\_\_ Did not enjoy cuddling    \_\_\_\_\_ Difficult to comfort    \_\_\_\_\_ Colic Irritability  
 \_\_\_\_\_ Diminished    \_\_\_\_\_ Excessive Sleep    \_\_\_\_\_ Head Banging    \_\_\_\_\_ Illness

**Testing & Diagnosis**

Has your child ever received? Psychiatric Evaluations  When: \_\_\_\_\_

Medical  Psychological Evaluations     Psychoeducational assessments     IQ testing

Comments/Additional information if applicable:

Location: \_\_\_\_\_ Phone# \_\_\_\_\_

Has your child ever been in any resource classes: \_\_\_\_\_ Please explain: \_\_\_\_\_

Has your child ever been tested for learning disabilities (list dates): \_\_\_\_\_

Please explain \_\_\_\_\_

Recommendations for further testing assessments: \_\_\_\_\_

Has your child been diagnosed by a Physician with a psychological, behavioral, or development disorder:

What were the resulting diagnosis: \_\_\_\_\_

Parents/Guardians must provide initial evaluation of appropriate placement & ensure that necessary information for service planning is provided.

**Academic Information**

*Previous Schools List most recent schools first:*

Information	School 1	School 2	School 3
School Name:			
Dates Attended:			
Address:			
City:			
State:			
Zip Code:			
Work Phone:			
FAX:			
Contact:			
Email (if known):			
Grades earned			

Information	School 4	School 5	School 6
School Name:			
Dates Attended:			
Address:			
City:			
State:			
Zip Code:			
Work Phone:			
FAX:			
Contact:			
Email (if known):			
Grades Earned			

Information	School 7	School 8	School 9
School Name:			
Dates Attended:			
Address:			
City:			
State:			
Zip Code:			
Work Phone:			
FAX:			
Contact:			
Email (if known):			
Grades Earned			

Has your child received any disciplinary actions at school? Please explain: \_\_\_\_\_

How would you rate her overall performance throughout her school years? \_\_\_\_\_

Has your child received any special achievements? \_\_\_\_\_

Describe any IEP goals and/or 504 plans: \_\_\_\_\_

Childs Distinguishing Marks: Scars or Tattoos/Other (Describe)

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Shirt Size: \_\_\_\_\_ Shoe Size: \_\_\_\_\_ Waist: \_\_\_\_\_ Length: \_\_\_\_\_

\* Please include your daughter’s most current psychological diagnosis and/or therapist assessments. Medical exam, dental exam, eye exam, hearing exam and the attached THRIVE medical form must be completed at least 30 days prior to admission into the THRIVE Girls Academy.

**PLANNING FACTORS:** Tentative date and time you would like to admit applicant \_\_\_\_\_

Means of transportation \_\_\_\_\_

### FINANCIAL OBLIGATION

**Pre-Admissions Intake Fee:** \$1000 To reserves your daughter’s Intake date into our program. A date for her intake cannot be scheduled until this fee has been received. (This can be paid by credit card)

**PROGRAM COSTS ON ADMISSIONS DATE:**

- Monthly Tuition: \$4150 x 2 = \$8,300 (First and Last Month’s tuition)
- Education/Curriculum Fee: \$1200 covers first 2 full credit courses
- Damage Fee: \$500 Fee for transport for medical, dental, or legal needs and/or any damage to property(In the event a student maliciously destroys property, the damage incurred will be covered by the parent in as fast a means as necessary)
- \*\*\*Student Account \$575 Limits of \$45 every month is placed on this, all receipts for anything purchased (recreation membership, haircuts, over the counter allergymedication, new shoes she grows into, etc.), and Bookkeeper will keep you informed if she is low on these particular funds.
- GPS Ankle monitor \$250 As needed, will be monthly only if student continues to be a flight risk after 30 days

Total Admissions Program costs due on or before day of Intake is \$10,575. Admissions/Intake Payment is accepted before or on Admissions date in the form of a cashiers check made to: Thrive Girls Academy  
**\*All fees and tuition payments are Non-Refundable regardless of length of stay.** Application & forms can be emailed to: [tga.admissions@tctexas.org](mailto:tga.admissions@tctexas.org) OR fax application & forms to FAX# 512-584-8535

### UNDERSTANDING OF FINANCIAL OBLIGATION

I/we understand ALL fees and tuition payments are Non-Refundable, regardless of length of stay.

Parent/Guardian (name & Signature) \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian (name & Signature) \_\_\_\_\_ Date \_\_\_\_\_

## MEDICAL FORM

Please fill out completely.

**Blood test results must be provided before your child will be entered into our program.**

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### PHYSICIAN'S STATEMENT

Upon examination of \_\_\_\_\_, I have, her, in my medical opinion, to be **free** from communicable diseases including:    TB  HIV  Hepatitis A, B and C

Pregnancy Test:         positive         negative

Has had recent travel outside of the U.S.? Explain: \_\_\_\_\_

Her overall **physical health** is:    Good                    Average                    Poor

Her overall **mental health** is:    Good                    Average                    Poor

Her overall **emotional health** is: Good                    Average                    Poor

**Handicaps** (Physical, Mental, Emotional): \_\_\_\_\_

**Specific treatment:** \_\_\_\_\_

**Drug Allergies or ANY known allergies:** \_\_\_\_\_

**Prescriptions:** \_\_\_\_\_

**Recommended Treatment or Follow up needed:** \_\_\_\_\_

In my opinion, the person is stable enough physically, mentally and emotionally to participate in a long-term group program involving teaching, learning, taking of responsibilities and strict discipline to help produce a self-disciplined life.

**Physicians Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Office Address:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

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**Please send email records of immunizations to [tga.admissions@tctexas.org](mailto:tga.admissions@tctexas.org) or mail to Adult & Teen Challenge of Texas, Thrive Girls Academy, Rev. Rodger Anderson, Executive Director, PO Box 1054, Hutto, TX 78634**

\*I understand that incomplete testing **will** delay the processing of my child's application.

Parent's or Legal Guardians Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## MEDICAL FORM

Parent/Legal Guardian please answer the following below to the best of your ability for your daughter

Student Name (print): \_\_\_\_\_

In the past 3 weeks, has your daughter experienced the following symptoms: fever, cough, difficulty breathing and respiratory congestion? Yes or No If yes, explain:

\_\_\_\_\_  
 \_\_\_\_\_

In the past 30 days, has your daughter traveled, lived or been in contact with someone that has traveled outside of the US? Yes or No If yes, explain:

\_\_\_\_\_  
 \_\_\_\_\_

In the past 3 weeks, has your daughter been on a cruise ship, or traveled outside of your state? Yes or No If yes, explain:

\_\_\_\_\_  
 \_\_\_\_\_

If it becomes evident for medical reasons that your daughter cannot be in the general population within our campus, where would you like her to be discharged to?

\_\_\_\_\_  
 \_\_\_\_\_

STUDENT TEMP: \_\_\_\_\_

Parents/Legal Guardian Name & Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## AUTOMATIC CREDIT CARD BILLING AUTHORIZATION

For automatic billing, simply complete the information below and sign the form. All **requested information is required**. Upon approval, we will automatically bill your credit card for the amount indicated and your total charges will appear monthly on your credit card statement. You may cancel this automatic billing authorization at any time by contacting us in writing or by email at least ten (10) days prior to **billing date**.

### Student Information

Student's name: \_\_\_\_\_ Enrollment Date: \_\_\_\_\_

### Payment Information

I, authorize THRIVE Girls Academy and Adult & Teen Challenge of Texas Inc. to automatically bill the card listed below as specified **(Monthly billing - All Fields are required)**:

Monthly Tuition Amount: \$ \_\_\_\_\_ Day of Month to Bill: \_\_\_\_\_ (At least 5 days before Tuition Due Date)

Month to Start billing On (MM/YY): \_\_\_\_\_ End billing when:  End Date (MM/DD/YY) \_\_\_\_\_.

Cardholder provides **written cancellation**  
(At least 10 business days prior to monthly billing date)

### Credit Card Information

The following credit cards are accepted (**Check One**):  **Visa**  **MasterCard**  **American Express**

Credit Card Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Cardholder's Name (as shown on credit card) \_\_\_\_\_

Card Verification Code \_\_\_\_\_ Credit Card Billing Zip Code: \_\_\_\_\_

Credit Card Billing Address: \_\_\_\_\_ Cardholder's Phone Number: \_\_\_\_\_

Cardholder's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Notify me via email or text when my credit card is charged. Email Address:** \_\_\_\_\_