PAYMENT POLICY

Credit Card Pre-authorization

Client Name: _____ Cardholder Name_____

Address: _____ City_____ State: _____ Zip Code: _____ Phone: _____

Date: _____ Card Billing Address: _____ City_____ State: _____ Zip Code: _____

I authorize Sano Consulting to charge my credit card account for:

- ❑ **Services rendered (see individual invoice)**
- ❑ Past services ❑ All visits this year
- ❑ Recurring charges for ongoing services $_____ Date: _____Other: _____

❑ **Visa** ❑ **Master Card** ❑ **Discover**

Charge Account Number: _____ Exp. Date_____ CCV # _____

I understand that this authorization is valid for one year unless I cancel it with written notice to the health care provider. By signing below I am agreeing to pay in full the amount I owe. I also understand that interest of 18% will be charged on a monthly basis on any outstanding balance beyond 60 days unless payment arrangements have been made.

Cardholder Signature **Date**

Returned Check Policy

Sano Consulting accepts checks as a form of payment; however should a check be returned due to insufficient funds, we will require immediate payment of another form plus a $35.00 returned check fee. If there is no response from you, we must send this to collections.

Signature **Date**

No Show / Appointment Cancellation Policy

I clearly understand and agree that a minimum of a 24 hour notice is required to cancel or reschedule an existing appointment. If I fail to notify the clinic within stated time frame, the first time will be given in grace; the 2nd time, 50% of the scheduled appointment time cost will be charged to me; the third time, 100% of the scheduled appointment time will be charged to me. Payment for the missed or no show appointment will be due immediately that day.

Signature **Date**

Service Agreement

I clearly understand and agree that all services and products rendered me are charged directly to me, and that I am personally responsible for payment. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable. There will be an 18% APR charged on balances over 60 days past due. Anything older than 120 days will be sent to collections. Please contact us if you have any questions regarding this policy.

Signature **Date**