



## Payment Policy

### Credit Card Pre-authorization

Name: \_\_\_\_\_ Cardholder Name: \_\_\_\_\_  
 Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Card Billing Address: \_\_\_\_\_ Date: \_\_\_\_\_

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 2<sup>nd</sup> 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** \_\_\_\_\_