FINANCIAL AGREEMENT

CLIENT NAME: _____ _____
First Name Last Name

FINANCIAL POLICIES

I understand that the fee for services will be paid at the conclusion of each session unless prior arrangements have been made.

I understand that I must notify Dr. Paul Day at least 24 hours in advance if I cannot attend the next scheduled session. Failure to give timely notice will result in me being charged the full fee for service. If I am able to reschedule a session within two business days, I will only be charged 25% of my regular rate for the missed appointment.

I understand that any outstanding balance on an account 30 days overdue is subject to a service charge of 1.5% per month.

I understand that if I have questions or concerns about the fees or payments, I am encouraged to discuss them openly at any time with Dr. Paul Day.

BILLING INFO:

Person Paying: ❑ Self ❑ Parent ❑ Guardian ❑ Friend ❑ Other _____

If Not Client _____ _____
First Name Last Name

Address: _____ _____ _____
Number & Street Name City Postal Code

BILLING CONSENT

_____ _____
Signature of Person Responsible for Payments Date

METHOD OF PAYMENT

- ❑ Credit card (Visa or MasterCard)
- ❑ Cash
- ❑ Check (for sessions, "**Active Back to Health**". For testing, "**PD Professional Services"**)
- ❑ PayPal
- ❑ E-transfer

CREDIT CARD PAYMENT PRE-AUTHORIZATION

If you would like to pre-authorize credit card payment to save on time, complete the fields below. Or you can set up this authorization when making payment at the reception desk.

Card Type: ❑ Visa ❑ Mastercard

Name Of Cardholder (as it appears on card): _____

Card Number: _____ - _____ - _____ - _____ **Expiration Date**: _____

CVV Code (3-digit code on back): _____

PAYPAL OR E-TRANSFER PAYMENT

If you would like to make a payment by Paypal, fill in the field below with your email address to receive an invoice via email.

Email Address: _____