

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 PD Professional Services |
Financial Agreement 2

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: _____