Card Payment Authorization

Email: Services@AdvancedClinicalNutrition.com Fax (940) 761-4405

My signature on this "Card Payment Authorization" document is:

1. Providing written confirmation that I have authorized Dr. Donna F. Smith, owner, and/or designated payment-processing (PP) employee of **Advanced Clinical Nutrition** (A.C.N.) permission to charge my credit or debit card for payment of all Clinical Nutrition Ministry Services and Products they provide for me. The term "Product" represents any tangible item, such as therapeutic or maintenance supplements to health equipment and appliances. **Please initial here: _____**

2. Acknowledgement that the services and products I received through A.C.N. are provided for dietary, nutritional and lifestyle education and improvement purposes only and not for the diagnosis or treatment of any medical condition, disorder or disease. **Please initial here: _____**

3. Acknowledgement that I understand that there is no refund or return on Analysis Fees, Lab Kits, Lab Requisitions, pre-paid consultations, or supplements and products subject to temperatures, whether they are dispensed to me for therapeutic or health maintenance purposes. This includes no refund on pre-paid Consultation Fees. **Please initial here: _____**

4. At least 48-hour notice to reschedule or cancel an appointment is required to avoid incurring a charge of 50% of the pre-scheduled appointment fee. **Please initial here: _____**

5. Acknowledgement that I am responsible for payment of services and products prior to receiving them, except for Progress Reporting consultations. I acknowledge that I am responsible for payment of consultation fees at the end of each fee-based consultation, which includes the fee for an additional time over the pre-paid consultation time that is included in some, but not all, Consultations and Analysis Fees for biochemical tests. **Please initial here: _____**

6. Acknowledgement that Dr. Smith or PP employee agrees to communicate (verbally or in writing, whichever applies), the purpose and amount of transactions, so I may provide verbal approval prior to actual card payment processing.

Date: _____ **Write Clearly. Use Blue or Black Ball Point Pen, not Gel Ink.**

_____Birthdate:_____

Signature: First, Middle and Last Name (18 yrs. or older or legal guardian) of Patient, your relationship.

_____Phone **(_____)**_____

Print: First, Middle and Last Name (18 yrs. or older or legal guardian) of Patient, your relationship.

_____

Card Statement Billing Address

_____

City, State and Zip Code

☐ **Check Box to indicate you have included a photo copy of the front and back of your credit or debit card to this document.**

After providing your signature and the above information, please make a copy of this document for your records, if desired. Then Email or Fax this signed completed document to us before mailing the original to us through your local postal service. See Heading for Fax # & Email Address. If fax line is busy, fax after 7 p.m. or before 10 a.m. C.S.T.

To receive ongoing services, the signed original of this document and card photocopy must also be mailed to:

Advanced Clinical Nutrition, P.O. Box 4652, Wichita Falls, TX 76308-0652