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.

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.

3. Acknowledgement that I understand that there is no refund or return on Analysis Fees, Lab Kits, Lab Requisitions, or supplements and products subject to temperatures, whether they are dispensed to me for therapeutic or health maintenance purposes.

4. Acknowledgement that I am responsible for payment of services and products prior to receiving them, except for 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 15-minute consultation time that is included in some, but not all, Analysis Fees for biochemical tests.

5. 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

_____ Phone **(_____)**_____

Print: First, Middle and Last Name

_____

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, unless we have enclosed a copy for you. 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, 4808 Shenandoah Drive, Wichita Falls, TX 76310

If you have any questions, please call Dr. Smith at (940) 761-4045. Thank you.