Name: _____ DOB: _____

PAYMENT & FINANCIAL INFORMATION

Who is financially responsible for this account?

Name: _____ DOB:_____
Relation: _____ SS#: _____
Address: _____
Phone: _____

By my signature below I acknowledge:

- All payment, including co-payment, is due at the time services are rendered.
- We accept cash, check, MasterCard, Visa, AMEX, or Discover for acceptable payment.
- A **$ 30.00 fee** is applied for all appointments that are not cancelled within 24 hours of your scheduled date/time of session. **Initials:** _____
- I will pay in full any and all outstanding balances and/or insurance claim which are denied within 30 days of receipt of invoice.
- I will have a late charge of 10% added to my balance if unpaid after 30 days.
- Any balance reaching more than 60 days past due will be sent through our collection process.
- Should my balance be sent for collection, I acknowledge that I will be responsible for all collection fees, as well as any legal fees, that ANW incurs in order to collect my balance.
- There is a **$ 30.00 fee** for a returned check**. Initials:** _____
- All nutrition packages are non-refundable but may be transferable to other in-house services. All packages expire 1 year after date of purchase.

SIGNATURE: _____

DATE: _____

(Financial Information Review)

I have reviewed the above information and agree in full to its content.

Signature: _____ **Date:**_____

_____ **Date:**_____

_____ **Date:**_____