Kerri Schwartz, MS, RD
2211 Corinth Avenue Suite 307 Los Angeles, CA 90064
310.312.4888

CREDIT CARD AUTHORIZATION

Payment is due when services are rendered unless and alternate payment plan is established with Kerri Schwartz, MS, RD. If payment is not made at the time of service or if you have an outstanding balance, then your credit card on file will be charged in the amount of the outstanding balance.

Payment guarantee: I understand that I am individually responsible for all incurred charges, even if I provide direct billing to another individual. If I direct bill to another individual who fails to make payment when due, I will provide payment promptly.

I understand that there is a 24 hour cancellation policy and that I will be charged if I fail to provide 24 hours advance notice to cancel a session.

I have read, understand and agree to the information and guarantee above.

Client signature: ____ Date: _________________

Client's printed name: ____

Please provide a credit card authorization regardless of your payment method
Credit card authorization: I, ____ (printed name) authorize the maintenance of a valid credit card to guarantee my agreed upon payment option.

Cardholder name: ____
Card type(please circle one): Visa MC AMEX

Billing address: ______________________________________ City: _______________ Zip: ________

Credit card #: ____ Expiration: _____/_____/_____

CVV code: ___________

Cardholder signature: ____ Date: _____________