SNOW BLOSSOM ACUPUNCTURE LLC
WELLNESS & FLOAT CENTER

We have implemented a new policy which requires all clients to keep a credit card on file for payment purposes. We have a system which enables us to maintain your credit card information securely on file and which can only be accessed under the terms you specify below.

By providing us with your credit card information, you are giving Snow Blossom Acupuncture, LLC permission to automatically charge your credit for all self-pay services due at the time of the visit.

Any canceled or missed appointments without 24-hour notice will result in the credit card on file being charged the current late cancellation/no show fee.

If the credit card information we have on file changes for any reason, you must notify Snow Blossom Acupuncture, LLC as soon as possible. If you have any questions about a charge, please notify us within 30 days. After 30 days all charges will be assumed to be correct.

We will maintain a clear record of all payments and charges. However, in the rare case that an overpayment occurs, your account will be credited on the upcoming invoice. If the balance is zero and you have taken a break from our services a reimbursement can be provided via a business check by request within 3 business days.

In the event of a declined charge, you will be asked for a new credit card number and/or payment before continuing treatments. Any additional fees incurred will be your responsibility as well.

This agreement will stay in effect indefinitely or until the card holder revokes this consent at any time in writing while understanding that continued services may not be available if unpaid balances accrue.

I HAVE READ AND UNDERSTAND THE CREDIT CARD ON FILE AGREEMENT AND AUTHORIZE SNOW BLOSSOM ACUPUNCTURE, LLC TO CHARGE MY CREDIT CARD AS STATED ABOVE.

CARD NUMBER: _____

EXP. DATE: _____ / _____ SECURITY CODE or CID #: _____

ADDRESS (street, city, state, and zip): _____

NAME ON CARD: _____

I, _____, authorize SNOW BLOSSOM ACUPUNCTURE, LLC to charge my credit card above for agreed upon services. I understand that my information will be saved for future transactions on my account.

Credit Card Holder's Signature: _____ Date: _____

Please fill out the information below for any other person(s) you authorize this credit card for:

Patient Full NAME: _____ DOB: _____ / _____ / ____