Dalit Szkolnik, MA, RD, LD/N, CEDRD-S

Registered Dietitian

Financial Consent

I, ___________________________________, am choosing to enter into services with Dalit Szkolnik. I understand that payment is due at the time that services are rendered.

As my appointment time has been set aside EXCLUSIVELY for me, **I understand that I am responsible for the session fee if I fail to cancel a scheduled appointment at least 24 hours in advance.** There is no fee if you cancel on time.

Any balance overdue more than thirty days will be subject to a $25 late fee PER MONTH. I agree to pay the cost of any delinquent bill, including attorney's fees. I understand that my account may be sent to a collection agency or court if fees are not paid in a timely fashion. If such action becomes necessary, I will be informed of such intent and I will be given an opportunity to settle the balance. If such action becomes necessary, only information to secure payment will be released. All other information will remain confidential.

Credit Card Information

Patient Name: ____

Cardholder Name: ____

Cardholder Number: ____

Security code- _________ Expiration Date: ___ /____ Billing Zip Code: __________________

My signature below signifies that I fully understand and agree with the above policies, and grant my permission to Nutrition Counseling Group, LLC to charge my credit card for any balance overdue or for any appointment that is not cancelled in the timely manner described above.

Patient/Guardian Signature: ___________________________ Date: _____________________