Megan Lukany LLC
5342 Clark Road, #1248
Sarasota, Florida 34233
Tel: 973-809-9270
Email: MeganLukanyLLC@gmail.com

CREDIT CARD ON FILE AGREEMENT

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 proving us with your credit card information, you are giving Megan Lukany LLC permission to automatically charge your credit card on a weekly, monthly, or as needed basis (if payment is not made by you within 15 days of a service appointment) for the amounts due for services received. These amounts match the receipts that have been provided to you at the completion of each therapy session.

Self pay services and other fees are still due at the time of the office visit. Any canceled or missed appointments without 24 hour notice will result in the credit card on file being charged the late cancellation/no show fee as outlined in your service agreement. ($25 for first time and full session rate for subsequent cancellations.)

If the credit card information we have on file changes for any reason, you must notify Megan Lukany LLC as soon as possible. If you have any questions about a charge please notify us within 15 days. After 30 days all charges will be assumed to be correct.

We will maintain 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 of if the balance is zero and you have taken a break from therapy a reimbursement can be provided via a business check.

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 expire upon the termination of services AND settlement of final balance. The card holder may also revoke 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 MEGAN LUKANY LLC TO CHARGE MY CREDIT CARD AS STATED ABOVE.

____ VISA ____ MASTERCARD ____ AMEX ____ DISCOVER _____ (Other)

CARD NUMBER: _____

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

Billing Zip Code: _____ NAME ON CARD: _____

I, _____, authorize MEGAN LUKANY 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: _____ / _____ / _____