Brian Buggie, MD ● 445 West 23rd Street, Suite 1EE ● NYC 10011 ● 646-580-8839

Financial Agreement

I, _____, am authorizing Dr. Brian Buggie to charge my credit card in the event that I fail to show for a scheduled appointment as recorded on my bill, or do not notify Dr. Brian Buggie of my inability to attend a scheduled appointment at least 48 business hours in advance.

Furthermore, for outstanding payments of services rendered, I authorize Dr. Brian Buggie to charge my credit card for the full amount due. I will not dispute charges for sessions I have received or that I have not cancelled less than 48 business hours in advance. I further authorize Dr. Brian Buggie to disclose information about my attendance/cancellation to my credit card company if I dispute a charge.

Card Type: ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Card #: Expiration Date:

Name as Printed on Card:

Verification/Security Code: (3–digit code on back by signature line)

Billing Address:

(Street, City, State & Zip)

Signature: Date:

(Patient or financially responsible party)

Please note: This form will be securely stored in your clinical file and may be updated upon request at any time. Your credit card will not be charged unless the following conditions apply: no–show for a scheduled appointment, cancellation less than 48 business hours in advance, or participation in treatment (e.g. appointment session) without payment rendered.