

**JAMES F. BATTAGLIA, PH.D.**  
**360 W 43rd Street, Apt. S9E**  
**New York, NY 10036**  
**646-455-3377**

Dear Patient,

This download contains the following forms:

- I. Informed Consent
- II. Intake Form
- III. HIPAA
- IV. Health Insurance Claim Form
- V. Cancellation Agreement

You can give me a completed hard copy when we meet or email me a completed scanned copy ahead of time to [dr.jb.psychologist@gmail.com](mailto:dr.jb.psychologist@gmail.com).

Special instructions for Form IV, Health Insurance Claim Form.

- 1. Print this form
- 2. Fill out boxes 1a – 6.
- 3. Go to box 12, Sign and date. (Your signature here allows me to submit a claim to your insurance company including demographic information and diagnosis.)
- 4. Go to Box 13, Sign. (Your signature here allows the insurance company to pay me for the services.)

If you have any questions about this, please ask me when we meet.

James F. Battaglia, Ph.D.  
Psychologist  
NYL 012304

## Form I - Informed Consent for Treatment

**PATIENT: RETAIN THIS PAGE FOR YOUR RECORDS**

**JAMES F. BATTAGLIA, PH.D.**  
**360 W 43rd Street, Apt. S9E**  
**New York, NY 10036**  
**646-455-3377**  
**docjb.com**

James F. Battaglia, Ph.D.  
Psychologist  
NYL: 012304

**INFORMED CONSENT FOR TREATMENT 2023**

**Welcome to my psychology practice!** I am looking forward to working with you and I will make every effort to accommodate your needs. So that you may be fully informed about the services you are receiving, please take the time to read the following information about our practice policies. **Please do not hesitate to ask any questions if any of the following seems unclear.**

I would like you to be aware of your right to confidentiality and our commitment to safeguard that right. The patient-therapist relationship is a confidential and privileged one, and is thus protected by law and ethical code. However, there may be limits to confidentiality depending on your particular circumstance. For example, if your health care carrier is under the Federal ERISA act, it is entitled to and may request information about your sessions. Likewise, PIP, Workers' Compensation, and other legal/court cases may override confidentiality. In cases in which there is a clear risk of harm to self or others or of suspected child abuse, confidentiality is limited by law.

If you have been referred for psychological or neuropsychological testing, I will assess the extent and type of testing that will be most useful in answering the diagnostic question. This may be done before or at the time of the first appointment, or as testing unfolds, depending on the nature of the case. *Please note, that an examination does not guarantee a specific diagnosis or set of recommendations.* These are made on a case-by-case basis according to the presentation of symptoms and particular needs of the examinee.

If you choose to engage in psychotherapy, please be aware that the process of psychotherapy involves change and can be an exciting process. At times, it may also seem frustrating and may arouse strong, difficult emotions. You may discover that the way you think about the world, the way you view your past, present, and future, and the way you relate to others may be altered. Therapy will require your work and commitment. My most important mission as a therapist is to help you make progress in your work toward reaching your goals. I will strive at all times to utilize my best clinical skills and professional judgment in this endeavor. In my work with children, please be mindful that parents/guardians should understand the need of their children to develop trust in a therapist. *Thus, I ask that parents/guardians limit their desire for specific details of the treatment.* However, I will be sure to address any concerns parents may have regarding their child's treatment.

**PATIENT: RETAIN THIS PAGE FOR YOUR RECORDS**

Individual sessions are usually scheduled to last from 45 - 60 minutes, depending on insurance. I will make every effort to begin your session on time and I appreciate your timeliness in keeping appointments. The frequency of therapy sessions is arranged by you and me, based on recommendations and your needs. You are free to terminate therapy at any time. Typically, termination is usually a mutual goal that is planned for by the patient and therapist. If at any time you feel that therapy is not meeting your needs, you are strongly encouraged to present your concerns to me.

Regarding billing, payment in full is due at the time the service is rendered. Information regarding fees is available upon request. I reserve the right to charge an interest charge of 1 ½% per month (18% per annual percentage rate) on accounts that are greater than 30 days overdue. There is also a returned check fee of \$25.00. Please note that in cases in which the account has been neglected by the patient and there has been no show of good faith despite our repeated attempts toward resolution, I reserve the right to turn the account over to a collection agency. In hardship circumstances, I am available to discuss payment arrangements.

If there is a matter that cannot wait until the next session, I am available by telephone at times other than your scheduled appointment. For a telephone call which lasts fifteen minutes or longer, I reserve the right to charge you a fee proportionate to the individual psychotherapy rate. If you have an emergency, and you call after regular business hours or cannot reach me, please call 991 or immediately go the emergency room of the nearest hospital.

I reserve the right to charge you for any missed appointments, or appointments that are canceled with less than 24 hours notice. I will not charge you if a health or family emergency arises. If an appointment is missed or canceled, I will reschedule you, hopefully during the same week.

*I am an in-network provider for Aetna, Cigna, and Compsych. I am not in-network for United Healthcare or Oxford any longer.*

*NOTE: Patients may need to meet a deductible before the provider begins payment to me. So, you are responsible for paying for services until deductible is met. Please check your plan!*

For patients with health plans in which I am not "in-network," you are responsible for paying the full fee at the time of service. *I encourage you to understand your plan's "out of network benefits," if any.* Unfortunately, I have learned that what your insurance provider/representative says over the phone is not always correct or clear. Ultimately, payment is your responsibility. I will assist you with the information you need to submit bills to your carrier. In some instances, I can bill electronically which will save you a step and get you reimbursed more quickly.

**PATIENT: COMPLETE THIS PAGE AND GIVE TO DR. BATTAGLIA**

**JAMES F. BATTAGLIA, PH.D.**  
**360 W 43rd Street, Apt. S9E New**  
**York, NY 10036**  
**646-455-3377**

I have read and understood the Consent for Treatment 2023 provided me by Dr. Battaglia. By signing below, I request services from Dr. Battaglia and agree to the provisions of the Consent for Treatment.

\_\_\_\_\_  
Print Patient Name

Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient if age 14 or over

Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent or Sole Legal Guardian  
if Patient is under 18 years of age

\_\_\_\_\_  
Signature of Other Parent if joint custody of Minor

I am a patient with (check one):

Cigna (I am responsible for full payment until deductible, if any, is met.)

Aetna (I am responsible for full payment until deductible, if any, is met

ComPsych (

Other Insurance Company: \_\_\_\_\_ (I am always responsible for full payment at time of service.)

None (I am always responsible for full payment at time of service.)

(Please photograph your health insurance card and text it to me at 201-755-0767.)

Also, please complete the following info:

ID: \_\_\_\_\_

Group: \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Insured's DOB: \_\_\_\_\_

## Form II - Adult Intake Form

**JAMES F. BATTAGLIA, PH.D.**  
**360 W 43rd Street, Apt. S9E**  
**New York, NY 10036**

**PATIENT INTAKE FORM 2023**

Please fill in the information below and bring it with you to your first session.  
Please note: information provided on this form is protected as confidential information.

**Personal Information**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Legal Guardian (if under 18): \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_

State: \_\_\_\_\_ Zip \_\_\_\_\_

Cell/Work/Other Phone: \_\_\_\_\_

Email: \_\_\_\_\_

*\*Please note: Email correspondence is not considered to be a confidential medium of communication.*

DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Marital Status:

- |  |  |
|--|--|
| <input type="checkbox"/> Never Married           | <input type="checkbox"/> Married               |
| <input type="checkbox"/> Divorced                | <input type="checkbox"/> Separated             |
| <input type="checkbox"/> Have partner<br>partner | <input type="checkbox"/> Don't have<br>partner |

Referred By (if any): \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Relationship: \_\_\_\_\_

Reasons for Seeking Therapy \_\_\_\_\_

**History**

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

No  Yes, previous therapist/practitioner: \_\_\_\_\_

Are you currently taking any prescription medication?

Yes  No If yes, please list medication and dose:

\_\_\_\_\_  
\_\_\_\_\_

Have you ever been prescribed psychiatric medication?

Yes  No If yes, please list medication and dose:

\_\_\_\_\_  
\_\_\_\_\_

**General and Mental Health Information**

1. How would you rate your current physical health? (Please circle one)

Poor            Unsatisfactory            Satisfactory            Good            Very good

Please list any specific health problems you are currently experiencing

\_\_\_\_\_  
\_\_\_\_\_

How would you rate our current sleeping habits (Please circle one)

Poor            Unsatisfactory            Satisfactory            Good            Very good



Please list any specific sleep problems you are currently experiencing:

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2. How many times per week do you generally exercise? \_\_\_\_\_

3. What types of exercise do you participate in? \_\_\_\_\_

4. Please list any difficulties you experience with your appetite or eating problems:

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5. Are you currently experiencing overwhelming sadness, grief or depression?  No  Yes

If yes, for approximately how long? \_\_\_\_\_

6. Are you currently experiencing anxiety, panics attacks or have any phobias?  No  Yes

If yes, when did you begin experiencing this? \_\_\_\_\_

Are you currently experiencing any chronic pain?  No  Yes

If yes, please describe: \_\_\_\_\_

7. Do you drink alcohol more than once a week?  No  Yes Times a week: \_\_\_\_\_

8. Do you use recreational drugs?  No  Yes

What? \_\_\_\_\_ How Often? \_\_\_\_\_

9. Are you currently in a romantic relationship?  No  Yes

If yes, for how long? \_\_\_\_\_

On a scale of 1-10 (with 1 being poor and 10 being exceptional), how would you rate your relationship?

1 2 3 4 5 6 7 8 9 10

What significant life changes or stressful events have you experienced recently?

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**Family Mental Health History**

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (e.g. Father, grandmother, uncle, etc.)

	Please Circle	Identify Family Member
Alcohol/Substance Abuse	yes / no	_____
Anxiety	yes / no	_____
Depression	yes / no	_____
Domestic Violence	yes / no	_____
Eating Disorders	yes / no	_____
Obesity	yes / no	_____
Obsessive Compulsive Behavior	yes / no	_____
Schizophrenia	yes / no	_____
Suicide Attempts	yes / no	_____

**Additional Information**

1. Are you currently employed?  No  Yes

Where do you work? What is your job?

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Do you enjoy your work? Is there anything stressful about your current work?

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2. Do you consider yourself to be spiritual or religious?  No  Yes

If yes, describe your faith or belief: \_\_\_\_\_

What do you consider to be some of your strengths?

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3. What do you consider to be some of your weaknesses?

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4. Have you been in psychotherapy before?  No  Yes

If yes, how long? \_\_\_\_\_

5. What would you like to accomplish out of your time in therapy? \_

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## Form III - HIPAA Notice

**JAMES F. BATTAGLIA, PH.D.**  
**PSYCHOLOGIST**  
**NEW YORK**

**Notice of Psychologist's Policies and Practices to Protect  
the Privacy of Your Health Information 2022**

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

**I. Uses and Disclosures for Treatment, Payment, and Health Care Operations**

James F. Battaglia, Ph.D., hereafter referred to as "I," may *use* or *disclose* your *protected health information (PHI)*, for *treatment, payment, and health care operations* purposes with your consent. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- "*Treatment, Payment and Health Care Operations*"
  - *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
  - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.

**II. Uses and Disclosures Requiring Authorization**

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "*authorization*" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization before releasing psychotherapy notes. "*Psychotherapy notes*" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

### **III. Uses and Disclosures with Neither Consent nor Authorization**

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If I have reasonable cause to believe that a child has been abused or neglected, I am required by law to report such information within 24 hours to the NYC Administration for Children's Services.
- 
- **Adult and Domestic Abuse:** If I have reasonable cause to believe that an elderly or disabled adult has been abused, neglected, or exploited, I am required by law to report this information to the county adult protective services provider .
- **Health Oversight:** If the New York State Board of Psychological Examiners issues a subpoena, I may be compelled to testify before the Board and produce your relevant records and papers.
- **Judicial or administrative proceedings:** If you are involved in a court proceeding and a request is made for information about the professional services that I have provided you and/or the records thereof, such information is privileged under state law, and I must not release this information without written authorization from you or your legally appointed representative, or a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. I will inform you in advance if this is the case.
- **Serious Threat to Health or Safety:** If you communicate to me a threat of imminent serious physical violence against yourself or a readily identifiable victim and I believe you intend to carry out that threat, I must take steps to warn and protect. I also must take such steps if I believe you intend to carry out such violence, even if you have not made a specific verbal threat. The steps I take to warn and protect may include arranging for you to be admitted to a psychiatric unit of a hospital or other health care facility, advising the police of your threat and the identity of the intended victim, warning the intended victim or his or her parents if the intended victim is under 18, and warning your parents if you are under 18.
- **Worker's Compensation:** If you file a worker's compensation claim, I may be required to release relevant information from your mental health records to a participant in the worker's compensation case, a reinsurer, the health care provider, medical and non-medical experts in connection with the case, the Division of Worker's Compensation or the Compensation Rating and Inspection Bureau.

#### **IV. Patient's Rights and Psychologists Duties**

##### **Patient's Rights:**

- *Right to Request Restrictions* - You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* - You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)
- *Right to Inspect and Copy* - You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- *Right to Amend* - You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request I will discuss with you the details of the amendment process.
- *Right to an Accounting* - You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice.) On your request, I will discuss with you the details of the accounting process.
- *Right to a Paper Copy* - You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

##### **Psychologist's Duties:**

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will notify you in person or by mail.

## **V. Questions and Complaints**

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact me, James Battaglia at 646-45-3377

If you believe that your privacy rights have been violated and wish to file a complaint with me, please contact:

New York's Professional Misconduct Enforcement System  
Complaint Hot Line:  
1-800-442-8106 or [conduct@mail.nysed.gov](mailto:conduct@mail.nysed.gov)

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

## **VI. Effective Date**

This notice has gone into effect on the date signed.

Your signature on the signature page acknowledges that you have read and understood the information in this document and agree to abide by its terms during our professional relationship.



**Acknowledgement of Receipt of HIPAA Notice 2023**

By your signature below, you indicate that you have received a copy of the “Notice of Psychologist’s Policies and Practices to Protect the Privacy of Your Health Information” from James F. Battaglia, Ph.D.

\_\_\_\_\_  
Signature of Patient if 14 years or older

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print your name above

\_\_\_\_\_  
Birthdate

\_\_\_\_\_  
Signature of Parent/Guardian if pt. is under 18 years

\_\_\_\_\_  
Signature of other Parent/Guardian if Joint Custody

## Form IV - Health Insurance Claim Form



# HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

CARRIER  
PATIENT AND INSURED INFORMATION

PICA <input type="checkbox"/>		PICA <input type="checkbox"/>	
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
CITY STATE		7. INSURED'S ADDRESS (No., Street)	
ZIP CODE TELEPHONE (Include Area Code) ( )		CITY STATE	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		8. RESERVED FOR NUCC USE	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		10. IS PATIENT'S CONDITION RELATED TO:	
b. RESERVED FOR NUCC USE		a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/>	
c. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____	
d. INSURANCE PLAN NAME OR PROGRAM NAME		c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>	
10d. CLAIM CODES (Designated by NUCC)		11. INSURED'S POLICY GROUP OR FECA NUMBER	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.		a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
SIGNED _____ DATE _____		b. OTHER CLAIM ID (Designated by NUCC)	
		c. INSURANCE PLAN NAME OR PROGRAM NAME	
		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, complete items 9, 9a, and 9d.	

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL		15. OTHER DATE MM DD YY QUAL		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a. _____		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
		17b. NPI _____		20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES _____	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____		22. RESUBMISSION CODE ORIGINAL REF. NO.	
		23. PRIOR AUTHORIZATION NUMBER			

24. A. DATE(S) OF SERVICE	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/>		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>		28. TOTAL CHARGE \$		29. AMOUNT PAID \$		30. Rsvd. for NUCC Use	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)				32. SERVICE FACILITY LOCATION INFORMATION				33. BILLING PROVIDER INFO & PH # ( )			
SIGNED _____ DATE _____				a. NPI		b. NPI		a. NPI		b. NPI	

PHYSICIAN OR SUPPLIER INFORMATION

## Form V - Cancellation Policy

**JAMES F. BATTAGLIA, PH.D**  
**360 W 43rd Street, Apt. S9E**  
**New York, NY 10036**  
**646-544-3377**  
**docjb.com**

**CANCELLATION POLICY AGREEMENT 2022**

I understand the following office policy regarding cancellation or failing to attend a scheduled appointment:

- 3+ When cancelling an appointment, I must give more than 48 hours notice. I understand there are exceptions, including illness and emergencies.
  - c0 If a cancellation is made less than 48 hours before the scheduled appointment, the reserved time may be forfeited and I may be placed on the waiting list until another time slot opens.
  - d0 If two appointments are epegrgf without giving 48 hours notice, the reserved time may be forfeited and I may be referred to another provider.
  
- 4+ I understand my credit card information is to be kept on file with Dr. Battaglia in a secure place. If an appointment is cancelled without the 48 hour prior notice, Dr. Battaglia will take that as consent to charge the session fee to credit card. Therefore, I have provided my credit card information below along with my consent that the missed session's fee be charged to the card.
  
- 5+ Kwpf gtucpf "vj cv'y j gp" c"ecpegrm v'kp'ku'o cf g'y kj kp'vj g'tgs wktgf "ko g'ltco g." F t0Dcwc i rlc'y kn'f q'j ku'dguv'vq'tguej gf wrg'o g'hqt "vj g'uco g'y ggn0"Kco "cy ctg" vj cv'vj ku'o c{ "pqv'dg'r qukdrg0
  
- 6+ Y j gp"ecpegrkpi "qt'tguej gf wkp'i "cp'cr r qpw gpv."Kci tgg'vq"eqpcevF t0 Dcwc i rlc'd{ "vgz'v'cv'423/977/2989"qt"go cki'o g'cv' f t0d0 u{ej qnqi kvB i o ckteqo "0

I agree to the above.

Signef <"aaaaaaaaaaaaaaaaaaaaaaaaaaaa

Date<"aaaaa"aaaaaaaaaaaaaaaaaaaaaaaaaaaa

\_\_\_\_\_

Please Print:

Name on Credit Card: \_\_\_\_\_

Credit Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_ CVV Code: \_\_\_\_\_