Plan

(the "Plan")

Authorization Form Debit Card / Credit Card Payment

I, _________________________________, authorize **LCA of WI, LLC (DBA Lice Clinics of America)** to process a monthly Debit or Credit Card payment as payment for the Plan. I understand that the Plan cost may be subject to change. I will be notified at least 30 days in advance of any changes in the amounts to be deducted and I will be provided the opportunity to cancel this authorization, if I wish to do so at that time. I understand the Plan fee will be processed each month the Plan is effective.

- ✓ *Initial: ____ The Plan allows for one head check per month for the individual(s) covered under the Plan, and free lice removal for the individual(s) covered under the Plan. The Plan limits free treatments to 3 per year. Once you have reached this limit you will be removed from the plan.*

- ✓ *Initial: ____ If lice removal is performed under this Plan, LCA strictly requires and you agree that <u>all</u> family members are checked and cleared, or treated by LCA with the AirAlle device as needed. All applicable charges apply to anyone not on the Plan. This requirement includes all step-parents/step-siblings, and may, at LCA's discretion, include grandparents/aunts/uncles/cousins, etc. depending on living arrangements*

- ✓ *Initial: ____ These additional head checks and treatments must be completed at the time of services rendered for Plan participants, and all standard and applicable charges apply for those who are not covered by the Plan.*

- ✓ *Initial:_____LCA retains the right to remove you from the plan at our discretion.*

- ✓ *Initial:____Your payment will be made automatically through our system monthly. If your payment does not go through you will be notified via email. Non-payment will result in removal from the Plan.*

By signing up for this Plan you are acknowledging and accepting these terms. ***LCA reserves the right to charge you full price for treatments received whenever these guidelines are not met.***

Each person added to the Plan must be head-checked and cleared by LCA at the time of Plan sign-up. Each sibling, step-sibling, and parent not covered by the Plan is required to have a head check and oil application at the time of treatment for a family member covered under the Plan.

[ ] Each Individual: $10.00

Name: ______________________________ Name: ______________________________

Name: ______________________________ Name: ______________________________

Name: ______________________________ Name: ______________________________

Total Monthly Plan: $_________

____
Name as shown on card (CC info only needed if not signing up in clinic)

____ Signature

____
Credit Card # **Exp Date** **CVV#**

______________________________ Email Address

______________________ Phone Number