



**C. Payment Information**

**The course fees (please check option)**

\_\_\_ \$5,000 course fee covers six month training and all course materials

\_\_\_ \$1,000 deposit to reserve your space, \$665/month for six months

**PAYMENT AUTHORIZATION**

I, (print name) \_\_\_\_\_ authorize Dr. Kalish, located at 19449  
Riverside Drive, #207 Sonoma, CA 95476 to bill my credit card as listed below.

\_\_\_\_\_  
**Name on Credit Card** \_\_\_\_\_

**Credit Card Holder's Billing Address** (Where your statement is mailed.)

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

**Credit Card Details**

Type of Credit Card (check one):     Visa     MasterCard     American Express

Credit Card # \_\_\_\_\_ Exp date \_\_\_\_\_

Last 3 digits (4 for Amex on front) on back of card \_\_\_\_\_  
(found on the back of your credit card on the signature panel)

**Student Billing Information**

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

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

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

**Authorization**

\_\_\_\_\_  
Card Holder's Signature

\_\_\_\_\_  
Today's Date

\_\_\_\_\_  
Student's Signature

\_\_\_\_\_  
Today's Date

This authorization may be revoked at any time when the following stipulations have been performed.

1. Student has already made new financial agreement that has been signed and dated or card holder/patient has submitted to our office a written request to revoke the card usage (stop billing credit card in writing signed and dated).
2. Student's account is paid in full.
3. All Credit cards will be charged on the first business day of every month for monthly payments.

D. Additional Information:

How did you hear about the course?

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Please submit your application:

[office@drkalish.com](mailto:office@drkalish.com),

Fax: 707-939-7488

Mail: 19449 Riverside Drive, #207 Sonoma, CA 95476

Phone: 1-800-616-7708