DR. JOEL SMALL
COACHING THE DENTAL MIND

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PAYMENT PROCEDURE

Client agrees that Dr. Joel Small will charge the monthly Coaching fee on the client's credit card #_____

O Visa O MasterCard O American Express

Charges will be deposited on the 1st of each month.

Name as it appears on the card: _____

Expiration date: _____

Address associated with card: _____

City, State & ZIP: _____

Signature indicates that client has read and agrees to the above.

Client_____Date_____