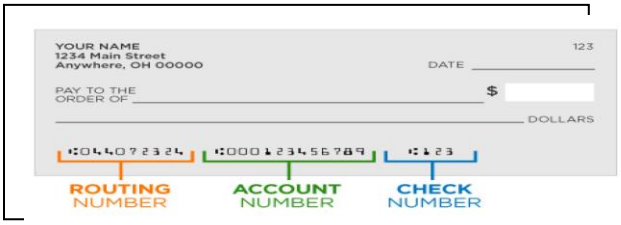
DERBY ORTHODONTICS

AUTHORIZATION FORM FOR RECURRING PAYMENTS

I authorize Derby Orthodontics to keep on file and withdraw regularly scheduled payments as defined below:

PLEASE ATTACH A VOIDED CHECK (DO NOT SIGN)
OR A BLANK DEPOSIT SLIP FOR SAVINGS ACCOUNT



ACCOUNT HOLDER INFORMATION:

Account Holder(s): _____
Phone#: _____
Address: _____
City: _____ State: _____ Zip:_____

CREDIT CARD PAYMENTS:

Card #: _____
Expiration Date: _____
Name on Card:_____

ACH PAYMENTS:

Routing Number:_____
Account Number:_____
Bank Name: _____

Monthly Payments will be withdrawn in the amount of $_____ on the _____ of every month.
Payments to begin _____ and end when full payment is received.
OR
Bi -Weekly Payments of $_____to begin on _____ and will end when full account balance is paid.
I understand Bi-Weekly payments will be withdrawn on each consecutive payday. (2 times a year this will result in 3 payments being withdrawn in one month.)

☐ *I request only 2 per month when applicable.*

ONE TIME TRANSACTIONS – Authorized for one time only transactions for the following amounts on the following dates:
$_____ Date:_____
$_____ Date:_____

☐ ***CHECK HERE IF FSA/HSA CLAIMS SUBSTANTIATION RECEIPT IS NEEDED***

I understand that ACH payments will be posted on the specified date above (or on the next business day if payment date falls on a weekend or holiday.) The amount of time for funds to be withdrawn from my account may be 3-5 business days depending on banking processing procedures. If adequate funds are not available for the payment posted and is returned insufficient, a charge of $36.00 will be added to my account as due and payable. In the event a total of 3 NSF payments occurs, I understand my ACH payments will be cancelled and another form of payment must be rendered.
A 48-hour notice is required to cancel my scheduled ACH payment(s). Once the payment is posted to my account it cannot be reversed.
My account will remain subject to its individual terms and conditions, which are not modified by this authorization. I understand that this authorization will remain in effect until the account balance is satisfied per the contract agreement or until Derby Orthodontics has received written notification from me of its termination in such time and in such manner to afford Derby Orthodontics and the DEPOSITORY a reasonable opportunity to act on it. I acknowledge that because this is an electronic transaction, these funds may be withdrawn from my account as soon as the above noted transaction date. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S law. I will not dispute merchant debiting my checking/savings account so long as the amount corresponds to the terms indicated in this agreement.

PATIENT NAME:_____
(Please print)

BANK ACCOUNT HOLDER NAME:_____
(Please print)

ACCOUNT HOLDER SIGNATURE: _____DATE:_____
REV: 5/2024