

Marshall Family Orthodontics
Authorization Agreement for Automatic Withdrawal of Funds

Patient ID# _____	Patient Name _____	
Name on Account (please print) _____		
Address _____		
City _____	State _____	Zip _____

Payment Information

Total Liability: \$ _____	
Monthly payment amount: \$ _____	Payment date: (1 st or 15 th) _____
Date of first payment: _____	Date of last payment _____
Total number of payments _____	Last payment amount \$ _____ (if different from monthly pymt amount)

Credit/Debit Card or Checking/Savings Account

Please charge payments directly to my:			
<input type="checkbox"/> Visa	<input type="checkbox"/> MasterCard	<input type="checkbox"/> Discover Card	
Card Number _____	Expiration Date _____		
Routing Number _____	Acct Number _____		
Signature _____	Date _____		

<p>I authorize Marshall Family Orthodontics, Inc. to process credit/debit entries from my account as indicated above. I understand that this authorization will remain in effect until I provide reasonable notification of its termination or until the end date specified above.</p> <p>Authorized Signature _____</p> <p>Date _____</p>	<p>I do not authorize Marshall Family Orthodontics, Inc. to process credit or debit entries from my account. I understand there will be a \$75.00 administrative/bookkeeping fee charged to my account. I also understand that there will be a \$25.00 late fee assessed if my account becomes 30 days past due. If my account becomes more than 60 days past due, active orthodontic treatment will be stopped until the account is brought up to date. A \$25.00 fee will automatically be charged to my account for every transaction returned due to insufficient funds (NSF).</p> <p>Authorized Signature _____</p> <p>Date _____</p>
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