AUTO PAYMENTS AUTHORIZATION

Patient's Name: _____

Responsible Party: _____

The Benefits of Auto Payments:

- **Convenience** – Since payments are due once a month and treatment is scheduled less frequently, you won't have to remember to mail in your payment
- **No Late Fees** – With today's busy schedules, avoid a late fee
- **Save Time and Money** – No stamps, no envelopes and no hassle
- **No Additional Cost to You!**

Your account will be set up as a reoccurring charge by the method chosen below. In compliance with the Privacy Act, we need your authorization acknowledging your automatic withdrawal of monthly charges on the **1st** business day of the month for credit/debit cards and on the **5th** of the month for checking/savings accounts.

Please fill out the appropriate information for the method chosen, **print clearly** and return to our office. Thank you for your cooperation.

Method of Payment: ☐ Checking Account ☐ Savings Account

Please attach a deposit slip marked Void for the appropriate account

_____

Routing Number Account Number……***Please Print Clearly***

_____ _____

Account Holder's Authorization Signature Date

Method of Payment: ☐ **Debit Card** ☐ **MasterCard** ☐ **Visa**

_____

Card Holder's Name

_____ _____

Credit/Debit Account Card Number……***Please Print Clearly*** Expiration Date

_____ _____

Card Holder's Authorization Signature Date