

# ORTHOBANC, LLC RECURRING PROGRESS PAYMENT PLAN

Orthodontist Drs. McCamish, Cooper, and Dyer Account # \_\_\_\_\_

Responsible Name:	Patient Name:
Responsible Address:	Responsible SSN:
City, State, Zip:	Email:
Home #:	Work #:

Amount of Total Withdrawal	Monthly Payment Amount	Final Payment Amount	Total Number of Monthly Withdrawals	Withdrawal Begin Date		
				Month	Day	Year
					5 12	19 26

## ORTHOBANC, LLC EFT AUTHORIZATION

I hereby authorize OrthoBanc, LLC (hereafter referred to as "OrthoBanc"), on behalf of the Orthodontist, to initiate debit entries to the account (s) indicated below via electronic funds transfer (EFT). I hereby authorize the financial institution(s) named below to accept and honor EFT withdrawals by OrthoBanc. I understand that beginning on the date listed above, OrthoBanc will begin withdrawals from my bank or credit card account. Such withdrawals will continue each month until the entire balance, provided to OrthoBanc by the Orthodontist, is paid in full. I understand that OrthoBanc is debiting funds from my account for payment to the Orthodontist and that the name OrthoBanc may/will appear on my monthly statement. I understand my final payment may be slightly more or less than the Monthly Payment Amount listed above, but will not exceed the balance of the account. Should the Orthodontist need to reduce the amount of my debit, the Orthodontist may notify OrthoBanc to reduce the Monthly Payment Amount without notification to me.

I further agree that should OrthoBanc be notified that funds are not available in my bank account (NSF, closed account, etc.) or that a charge to my bankcard is denied, a \$20 fee will be charged by OrthoBanc. I agree that if funds are not available from the account I choose as primary, OrthoBanc can attempt to secure funds from my secondary account. If no secondary account is provided, OrthoBanc can re-draft my primary account. I understand that if I choose to discontinue this method of payment I must notify OrthoBanc, a minimum of 7 days prior to my scheduled debit date.

**Please select the primary and secondary accounts OrthoBanc is to debit:**

Primary Account	Secondary Account
<input type="checkbox"/> Checking * <input type="checkbox"/> Savings  Name(s) as it appears on your account _____  Bank Account # _____      Routing # _____	<input type="checkbox"/> Checking * <input type="checkbox"/> Savings  Name(s) as it appears on your account _____  Bank Account # _____      Routing # _____
<input type="checkbox"/> Credit Card *      Card Type _____ Credit Card # _____ Expiration Date _____	<input type="checkbox"/> Credit Card *      Card Type _____ Credit Card # _____ Expiration Date _____

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

SSN: \_\_\_\_\_

For Orthodontist use only: PID Number: of00001003/op00001003 Patient OrthoBanc Ref No:
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