



Auto Payment Authorization

Today's Date _____ Patient # _____

Patient Name _____

Responsible Party Name _____ SS# _____

Credit/Debit Card

Account # _____ Credit Card: VISA MASTERCARD

Expiration Date _____ Verification # (3 digit code on back of card) _____

Cardholder's Name _____

Draft Date – 1st OR 15th (please circle one)

Authorized Signature _____

All account or draft changes must be submitted in writing and signed by the above party within 7 days of draft date.

I authorize Parks Orthodontics to automatically debit the above account until the entire contracted balanced is paid in full. I further agree that in the event that funds are not available in above account or if charges are denied, a fee of \$20 will be charged by Parks Orthodontics.

Office Use Only

Total Withdrawal \$ _____ Monthly Payment Amount \$ _____

Final Payment Amount \$ _____ Total Number of Monthly Withdrawals _____