VONDRAN ORTHODONTICS

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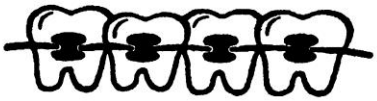

Please choose a date to be auto drafted:

3, 9, 17 or 24

Dear Patient,

For your convenience, we will be happy to automatically debit your monthly payments each month for you. Please complete the information below:

Patient Name: _____

I authorize the health care provider shown above to charge my credit card account for my monthly payments.

Please Note: A 3.5 % processing fee will be added to the amount financed with a credit or debit card.

____ MC ____ VISA ____DISC

____ OTHER _____

Amount Per Month:_____ Start Month:_____ Day:_____

Charge Account Number:_____ Exp. Date:_____

CVC #:_____

Cardholder Name: _____

I understand that this contract is valid throughout my payment contract unless I cancel the authorization with written notice to the health care provider.

Cardholder Signature:_____

Date: _____