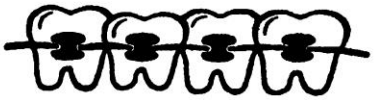
VONDRAN ORTHODONTICS

Charles A. Vondran, Jr. D.D.S., M.D.S.



DIRECT DEBIT AGREEMENT

Please choose a date to be auto drafted:

1, 7, 15 or 22

Name on account:_____

Patient's Name:_____ Amount: $_____

BEGIN: Month/Day/Year:_____

Financial Institution Information:

PLEASE ATTACH A VOIDED CHECK

Name of Financial Institution: _____

Routing #:_____Account #:_____

Checking account ____ or Savings account: ____

Authorization:

I hereby authorize **Vondran Orthodontics** to initiate direct debit entries to my checking/savings account indicated above and the Financial Institution about to post the same to such account.

This authorization is to remain in force until **Vondran Orthodontics** receives written notice of cancellation from me. This notice of cancellation must be received at least 30 days prior to cancellation and in such manner as to afford **Vondran Orthodontics** reasonable opportunity to act on it and in no event shall it be effective with respect to entries processed by **Vondran Orthodontics** prior to the receipt of the notice of cancellation.

I further authorize **Vondran Orthodontics** to initiate such credit entries to said account as may be necessary to correct any erroneous debit entries previously initiated thereto and I authorize the Financial Institution to accept and to credit or debit the amount of such entries to my account.

Signed: _____ **Date:** _____