FINANCIAL AGREEMENT

Patient Name:____________________________________

PLEASE CHOOSE THE OPTION THAT WORKS BEST FOR YOU:

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circle one:

CHECKING ACCOUNT DEBIT **SAVINGS ACCOUNT DEBIT**

1st, 7th, 15th or 22nd

Name on Account:____
Account Number:____
Financial Institution:____
City:__________________________________State:__________________ Zip:___________
Routing Number:_______________________________ Amount:_________________________
Begin: _____________________________
month/date/year

CREDIT CARD AUTO DEBIT

3rd, 9th, 17th or 24th

Cardholder Name:____

VISA MASTERCARD DISCOVER
OTHER________________

Account Number:__________________________________Expiration:_________CVC:______
Amount per month:____________________Start month:_________________Day:___________

I hearby authorize Vondran Orthodontics to initiate direct debit entries to my checking/saving/credit card 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 preciously initiated thereto and I authorize the financial institution to accept and to credit or debit the amount of such entries to my account.

Signature: Date: