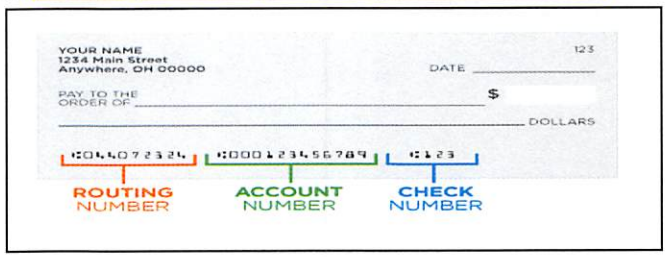
DERBY
ORTHODONTICS

AUTHORIZATION FORM FOR RECURRING PAYMENTS

I authorize Derby Orthodontics to keep on file and withdrawal regularly scheduled payments through my checking/savings account.

PLEASE ATTACH A VOIDED CHECK (DO NOT SIGN)
OR A BLANK DEPOSIT SLIP FOR SAVINGS ACCOUNT



ENTER BANK ACCOUNT INFO:

☐ Checking Account ☐ Savings Account**
Name on Account:_____
Bank Name:_____
Routing Number:_____
Account Number:_____
Bank City/State: _____

***Federal Reserve Regulation D – A total of 6 withdrawals per month (or 4 week statement cycle) are allowed. I understand that if my payment is returned unpaid, a fee of $36.00 will be charged.*

Payments will be withdrawn in the amount of $_____ on the _____ of every month. Charges will begin _____ and end when full payment is received.

ONE TIME TRANSACTIONS – Authorized for one time only transactions for the following amounts on the following dates:

$_____ Date:_____
$_____ Date:_____
$_____ Date:_____
$_____ Date:_____

☐ ***Check here for flex receipts to be mailed***

I understand that ACH payments will be posted on the specified date above (or on the next business day if payment date falls on a weekend or holiday). The amount of time for funds to be withdrawn from my account may be 3-5 business days depending on banking processing procedures. Adequate funds need to be available for payments to avoid an insufficient funds charge of $ 36.00. If a total of 3 NSF payments occur, I understand my ACH payments will be cancelled and another form of payment must be rendered.
A 48 hour notice must be given to cancel my scheduled ACH payment(s). Once the payment is posted to my account it cannot be reversed.

My account will remain subject to its individual terms and conditions, which are not modified by this authorization. I understand that this authorization will remain in effect until the termination date stated above or until Derby Orthodontics has received written notification from me of its termination in such time and in such manner to afford Derby Orthodontics and the DEPOSITORY a reasonable opportunity to act on it. I acknowledge that because this is an electronic transaction, these funds may be withdrawn from my account as soon as the above noted transaction date. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S law. I will not dispute merchant debiting my checking/savings account so long as the amount corresponds to the terms indicated in this agreement.

PATIENT NAME:_____
(Please print)

BANK ACCOUNT HOLDER NAME:_____
(Please print)

BANK ACCOUNT HOLDER SIGNATURE:_____

DATE:_____

Revised 6.17.19