

Authorization Agreement for Automatic Withdrawal of Funds

Patient ID # _____

Name (please print) Primary Guardian: _____ Patient's Name _____
 Secondary Guardian (if applicable): _____

Address _____

City _____ State _____ Zip _____

Please debit monthly payments from my (check one):

- Check Account (attach voided check)
- Savings Account (attach savings deposit slip)

Routing # is located at bottom of check between the symbols |: _____

Account Number _____

Payment Information

Please debit my down payment of \$ Not Applicable (leave blank if not applicable) on Not Applicable (date of down payment).

Monthly payment amount: \$ _____ Payment date (please circle one): 1st 15th

Date of first payment: _____ (mm/yy) Date of last payment _____ (mm/yy)

Total number of payments _____ Last payment amount \$ _____
 (if different from monthly payment amount)

As a courtesy, Drs. Dunn and Savastano have provided you with an interest free loan with our office. The treatment fee (payments made to Drs. Dunn & Savastano) reflects services (braces and the maintenance of the braces) provided by Drs. Dunn & Savastano. Any procedures needed to aid in the orthodontic treatment such as extractions, exposures, oral surgery of any nature, fillings, restorative work, dental cleanings & x-rays, etc. are *not included* in this fee. This is the patient/guardian's responsibility to pay for these procedures to the rendering doctors not affiliated with this practice. All patient and insurance balances must be paid in full prior to the removal of the appliances. This is the responsible party's responsibility to pay these balances off in full regardless of any payment arrangements and will be refunded by the insurance company directly any benefits that are due. If for any reason estimated insurance is not received, or there is a change from an indemnity plan to a discount plan the responsible party will assume the unpaid balance I authorize Drs. Dunn and Savastano and Vanco Services, LLC to process monthly debit entries from my checking or savings account indicated above. I understand that this authorization will remain in effect until I have it canceled, or until the end date specified above. If I must deviate from the above-mentioned payments for any reason, it is my responsibility to contact your bookkeeper, Brenda, directly. I understand that there will be \$30.00 fee automatically charged to my account form every transaction returned due to insufficient funds (NSF). I have attached a voided check or savings deposit slip. By signing this I authorize Drs. Dunn & Savastano to debit my checking or savings account for orthodontic reoccurring billing and agree to the terms and conditions mentioned above.

Authorized Signature: _____ Date _____

Print Name of authorized Signature Above: _____ Relationship to Patient? _____

Attach voided check here.