Orthodontist Dr. Paul Batastini - Cherry Hill Account #

Responsible Name:	Patient Name:
Responsible Address:	Responsible SSN:
City, State, Zip:	Email:
Home #	Work #

Amount of Total Withdrawal	Monthly Payment Amount	Final Payment Amount	Total Number of Monthly Withdrawals	Withdrawal Begin Date		
				Month	Day	Year
					5 12 19	

I hereby authorize Batastini Orthodontics to initiate debit entries to the account(s) indicated below via electronic funds transfer (EFT). I hereby authorize the financial institution(s) named below to accept and honor all EFT withdrawals by Batastini Orthodontics. I understand that beginning on the date listed above, Batastini Orthodontics will begin withdrawals from my bank account or credit card account. Such withdrawals will continue each month until the entire balance is paid in full. I understand my final payment may be slightly more or less than the monthly payment amount listed above, but will not exceed the balance of the account. Should Batastini Orthodontics need to reduce the amount of my debit, that amount may be reduced without notification to me.

I further acknowledge and agree that should Batastini Orthodontics be notified that funds are not available in my bank account (NSF, closed account or otherwise) or that a charge to my bankcard is denied, a $35.00 fee will be assessed to the patient account. I agree that if the funds are not available from the account I choose as a primary account, Batastini Orthodontics may attempt to secure the funds from my secondary account. If no secondary account is provided, Batastini Orthodontics can re-draft my primary account. Any changes to the payment arrangement must be done a minimum of seven (7) days prior to my scheduled debit date.

NEW CONTRACT	CHANGE EFFECTIVE DATE	ADJUSTMENT

DEFERRED DOWNPAYMENT	DATE & AMOUNT

WE ACCEPT CHECKING, SAVINGS, VISA, MASTERCARD, DISCOVER, AND AMERICAN EXPRESS

Primary Account	Secondary Account
☐ Checking *	☐ Checking * ☐ Savings
Name(s) as it appears on your account	Name(s) as it appears on your account
Bank Account # Routing #	Bank Account # Routing #
☐ Credit Card * Card Type	☐ Credit Card * Card Type
Credit Card #	Credit Card #
Expiration Date SECURITY CODE	Expiration Date

Signature: Date:

SSN:

**If using a credit card or Health Savings Account card for reoccurring monthly payments, there will be a $75.00 processing fee included with the first payment for the set-up fee.