ORTHOBANC, LLC

RECURRING PAYMENT PLAN

Orthodontist Dr. Lance E. West - Medford Account #

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

Amount of Total Withdrawal	Monthly Payment Amount	Final Payment Amount	Total Number of Monthly Withdrawals	Withdrawal Begin Date		
				Month	Day	Year
					5 12 19 26	

ORTHOBANC, LLC EFT AUTHORIZATION

I hereby authorize **OrthoBanc, LLC** (hereafter referred to as "OrthoBanc"), on behalf of the Orthodontist, 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 EFT withdrawals by **OrthoBanc**. I understand that beginning on the date listed above, **OrthoBanc** will begin withdrawals from my bank or credit card account. Such withdrawals will continue each month until the entire balance, provided to **OrthoBanc** by the Orthodontist, is paid in full. I understand that **OrthoBanc** is debiting funds from my account for payment to the Orthodontist and that the name **OrthoBanc** may/will appear on my monthly statement. 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 the Orthodontist need to reduce the amount of debit, the Orthodontist may notify **OrthoBanc** to reduce the Monthly Payment Amount without notification to me.

I further agree that should **OrthoBanc** be notified that funds are not available in my bank account (NSF, closed account, etc.) or that a charge to my bankcard is denied, a $20 fee will be charged by **OrthoBanc**. I agree that if funds are not available from the account I choose as primary, **OrthoBanc** can attempt to secure funds from my secondary account. If no secondary account is provided, **OrthoBanc** can re-draft my primary account. I understand that if I choose to discontinue this method of payment I must notify **OrthoBanc**, a minimum of 7 days prior to my scheduled debit date.

Please select the primary and secondary accounts OrthoBanc is to debit:

Primary Account	Secondary Account
☐ Checking * ☐ Savings	☐ 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	Expiration Date

Signature: Date:

SSN:

For Provider use only:		For OrthoBanc, LLC use only:	
OID/PID Number: of00001754/op00001877	Patient OrthoBanc Ref No:	Received:	Initials:

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