

Dr. Jackson, Orthodontist
Automatic Payment Plan Enrollment Form

For your Checking Account to be drafted each month, please print the following information:

Patient Name: _____

Name: _____

City: _____ State: _____ Zip Code: _____

Please enter the day you would like your payments to be processed and the month you would like this transaction to begin: (Please note the day must be between the 1st and the 28th)

Day of month: _____ Month to start: _____

I hereby authorize an automatic debit on the account designated below for my monthly orthodontic charge of \$_____ until the account amount is paid in full.

Signature: _____ Date: _____

Bank Name: _____

Bank Routing Number: _____
(This number is the first 9 digits in the bottom left hand corner of your check)

Account Number: _____
***** **Please attach a Voided Check to this form** *****

For your Credit Card to be automatically charged each month please print the following information:

Patient Name: _____

Visa Master Card Discover American Express

Credit Card # : _____ - _____ - _____ - _____ Exp Date: ____/____

Cardholder Name: _____

Cardholder Billing Address: _____

City: _____ State: _____ Zip Code: _____

I authorize CPOS to keep my signature on file and to charge my account listed above for recurring charges of \$_____ every month, starting the first deduction to be withdrawn on _____20_____. I understand that this form is valid for the length of the contract signed between CPOS and myself unless I cancel the authorization through written notice to CPOS.