



AUTHORIZATION FORM FOR RECURRING PAYMENTS

I authorize Trimmell & Anders Orthodontics to keep on file and withdrawal regularly scheduled payments through my debit/credit/flex card.

CIRCLE ONE:

VISA MASTERCARD DISCOVER AMERICAN EXPRESS

Cardholder Name: Phone Number: Cardholder Address: City: State: Zip: Card Number: Expiration Date: CVS#: (on back of card)

Payments will be withdrawn in the amount of \$ on the of every month.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

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 Trimmell & Anders Orthodontics has received written notification from me of its termination in such time and in such manner to afford Trimmell & Anders Orthodontics and the DEPOSITORY a reasonable opportunity to act on it.

PATIENT NAME: (Please print)

CARDHOLDER NAME: (Please print)

CARDHOLDER SIGNATURE:

DATE: