If you choose to draft from debit/credit card, there will be an additional 3% added

Responsible Name:	Patient Name:
Responsible Address:	
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	

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 #
3% Added for credit - Debit Card	
☐ Credit Card * Card Type	☐ Credit Card * Card Type
Credit Card #	Credit Card #
Expiration Date	Expiration Date

ORTHOBANC, LLC EFT AUTHORIZATION

I hereby authorize **OrthoBanc, LLC** (hereinafter "**OrthoBanc**"), on behalf of the Orthodontist, to initiate debit entries to the account(s) indicated above (of which I am an authorized signer) via electronic funds transfer (EFT). I understand that beginning on the date listed above, **OrthoBanc** will begin withdrawals from my bank or credit/debit card account. Such withdrawals will continue each month until the entire balance, provided to **OrthoBanc** by the Orthodontist, is paid in full. I understand should my financial institution debit my account before the effective date supplied by **OrthoBanc** to the financial institution in its processing file, that this is not a processing error on behalf of **OrthoBanc**. I understand **OrthoBanc** is debiting funds from my account for payment to the Orthodontist, for professional services rendered, and the name **OrthoBanc** may/will appear on my monthly statement. I understand my final payment may be slightly more/less than the Monthly Payment Amount listed above, but will not exceed the balance of the account at **OrthoBanc** as of the date of the payment.

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 credit/debit card is denied, a $25 failed payment 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 if I choose to discontinue this method of payment I must notify **OrthoBanc** a minimum of 4 business days prior to my scheduled debit date. I also authorize **OrthoBanc** to contact me at any of the telephone numbers listed above regarding this account, including through use of an autodialer, or text or prerecorded messaging. I agree to notify **OrthoBanc** immediately if my cell phone numbers change.

Signature: _____

For Provider use only:	
OID/PID Number:	of00001223/op00001237

900 S Broadway, Suite 100, Denver CO 80209
P: 800-636-6600 F: (888) 758-0586 www.orthobanc.com