

# Payment Plan Details and Recurring Payment Authorization Form



I \_\_\_\_\_ (or a family member) will / have receive(d) care from Health Centered Dentistry and, in lieu of payment in full, am agreeing to a payment plan for the balance. Therefore, I authorize Health Centered Dentistry to charge my account each month for payment of the obligation.

This is how recurring payments work:  
You authorize regularly scheduled charges to your checking/savings account or credit card. Your payment will be processed, for the amount indicated, each month. You agree that no prior notification will be provided. *On your checking account statement, the charge will appear as an "ACH Debit."*

Treatment Fee: \$ \_\_\_\_\_

**Down Pymnt:** \$ \_\_\_\_\_

3% Financing Fee: \$ \_\_\_\_\_

Balance to be Financed: \$ \_\_\_\_\_

The responsible party hereby agrees to pay the total "Balance to be Financed" listed as follows:

\_\_\_\_\_ monthly payments of \$ \_\_\_\_\_.

Day of the month to draw funds:  1<sup>st</sup>  15<sup>th</sup>

## Checking/ Savings Account

Checking  Savings

\_\_\_\_\_  
Name on Acct

\_\_\_\_\_  
Bank Name

\_\_\_\_\_  
Account Number

\_\_\_\_\_  
Bank Routing #

Choose the option that works best for your situation....

**A 3% processing fee will be added to all auto-payments processed by CC**

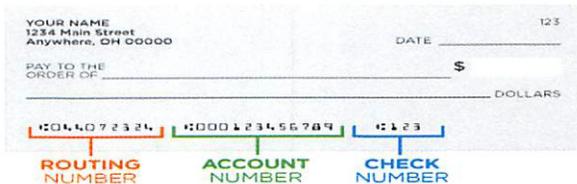
## Credit Card

\_\_\_\_\_  
Cardholder Name

\_\_\_\_\_  
Account Number

\_\_\_\_\_  
Exp. Date

\_\_\_\_\_  
CVV



SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the above named business in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. For ACH debits to my checking/savings account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Non Sufficient Funds (NSF) I understand that the above named business may at its discretion attempt to process the charge again within 30 days, and agree to an additional charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank or credit card company; so long as the transactions correspond to the terms indicated in this authorization form.