



Automatic Payment Plan

Patient Name: \_\_\_\_\_ Account #: \_\_\_\_\_

Start Date: \_\_\_\_\_ Would you like a Monthly Statement? \_\_\_\_\_

**AUTOMATIC DEBIT FROM CHECKING ACCOUNT**

I authorize OrthoSynetics to deduct \$\_\_\_\_\_ from the following account on the \_\_\_\_ of each month. I understand the draft will continue until the account balance is paid in full, or I give verbal or written authorization to discontinue draft. A charge of \$25 will apply to any returned checks.

Name on Account: \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

9 Digit Routing #: \_\_\_\_\_

Account #: \_\_\_\_\_

Signature: \_\_\_\_\_

**PLEASE ATTACH A VOIDED CHECK**

**AUTOMATIC CREDIT CARD CHARGE**

I authorize OrthoSynetics to charge \$\_\_\_\_\_ to the following card on the \_\_\_\_ of each month. I understand the draft will continue until the account balance is paid in full, or I give verbal or written authorization to discontinue draft.

Name on Account: \_\_\_\_\_

Billing Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Visa  MasterCard  Discover  American Express

Account #: \_\_\_\_\_ Exp. Date \_\_\_\_/\_\_\_\_

Signature: \_\_\_\_\_

**PLEASE ATTACH A PHOTOCOPY OF CARD**