Automatic Payment Authorization Form

If interested in having _____'s treatment account paid automatically via credit card or bank draft, please complete the following, where appropriate, and return to Dr. Fiorenti's Office.

CREDIT CARD AUTHORIZATION:

I authorize the orthodontic office of Charles P. Fiorenti, DDS to keep my signature on file and to charge my:

Visa / MasterCard / American Express / Discover Card

Recurring monthly charges of $_____ , from _____ to _____
(Date) (Date)

Credit Card Account Number _____

Expiration Date _____ Security Code _____
Month/Year

I understand that this form is valid unless I cancel the authorization via written notice to the office of Charles P. Fiorenti, DDS..

_____
Cardmember Name

_____
Cardmember Billing Address

_____
City State Zip

X_____ _____
Cardmember Signature Date

DIRECT PAYMENTS FROM BANK ACCOUNT (ACH DEBITS):

I hereby authorize the office of Charles P. Fiorenti, DDS, herein called COMPANY, to initiate debit entries to my: (select one)

Business Checking Account / Personal Checking Account / Business Savings Account / Business Savings Account

indicated below at the depository financial institution named below, herein called DEPOSITORY, and to debit the same to such account. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law.

Depository
Name:_____Branch:_____

City:_____State:_____ Zip:_____

Routing Account
Number:_____Number:_____

This authority is to remain in full force and effect until company has received written notification from me of its termination in such time and in such manner as to afford Company and depository reasonable opportunity to act on it.

X_____ _____
Account Holder Signature Date

NOTE: DEBIT AUTHORIZATIONS MUST PROVIDE THAT THE RECEIVER MAY REVOKE THE AUTHORIZATION ONLY BY NOTIFYING THE ORIGINATOR IN THE MANNER SPECIFIED IN THE AUTHORIZATION.