ELFMAN ORTHODONTICS, LLC RECURRING PROGRESS PAYMENT PLAN

The remaining balance of your treatment cost will be withdrawn each month from your bank or credit card account based on the following schedule, until paid in full.

Amount of Total Withdraw	Monthly Payment Amount	Final Payment Amount	Total Number of Monthly Withdraws	Withdraw Begin Date
$	$	$		Month ____ Day 15 ____ Year

ELFMAN ORTHODONTICS, LLC EFT AUTHORIZATION

I hereby authorize Elfman Orthodontics, LLC (hereafter referred to as "Orthodontist") to collect the Remaining Balance above according to the schedule listed above via electronic funds transfer (EFT). I hereby authorize the financial institution named below to accept and honor EFT withdrawals by Orthodontist. I understand that each month beginning on the date listed above, Orthodontist will withdraw from my bank or credit card account the Monthly Payment Amount. Such withdrawals will continue each month until the entire Remaining Balance is paid in full. I understand that Orthodontist is collecting funds from my account and that the name Elfman Orthodontics, L.L.C. may appear on my monthly statement.

I further agree that should Orthodontist be notified that funds are not available in my bank account (NSF or closed account) or that a charge to my bankcard is denied, a $20 fee will be charged by Elfman Orthodontics, L.L.C. and that treatment by Orthodontist may be interrupted if the Monthly Payment Amount and the $20 fee is not paid within 15 days of notification. I agree to inform Orthodontist with any change of information, including the credit card expiration date and if funds are not available from the account I choose as primary, Orthodontist can attempt to secure funds from my secondary account. If no secondary account is provided, Orthodontist can re-draft my primary account. I understand that I am in control of this electronic payment method and that I may choose to discontinue this method of payment by notifying Elfman Orthodontics, L.L.C. in writing, a minimum of seven (7) days prior to my scheduled debit date.

PTS ACCOUNT # **PATIENT NAME:** Date:

Checking Or

Bank Name

Checking ☐ Savings ☐

Bank Acct #

Routing #

Credit Card

Visa MasterCard AMEX Discover

Credit Card #

Expiration Date

CREDIT CARD or CHECK HOLDER INFORMATION:

Print Name: *(As it appears on credit card or checking acct)*

Signature: _____

Address:

(Street, Town, Zip)

Email: *(Please print clearly!)*

Home Phone #

Note: Elfman Orthodontics, LLC Account setup: Signature and Copy of Check or Credit card MUST have the same responsible name listed