PRE-AUTHORIZED PAYMENT FORM

By signing, I hereby authorize Shasta Orthodontics, Inc. (c/o Karen McCarthy, D.D.S., M.S.) to debit my credit card account or bank account in the amount of $_____ beginning _____/_____/_____ and continue until my balance is PAID IN FULL.

Shasta Orthodontics, Inc. will debit my account listed below on the _____ day of each month. If this date should fall on a weekend or holiday, I understand that my payment will be deducted the following business day. I acknowledge the debit to my account will have Shasta Orthodontics, Inc. as a creditor.

I will notify Karen McCarthy, D.D.S., M.S. through verbal or written communication of any changes to the account information or termination of these authorization prior to the next due date of the pre-authorized debit.
A service charge of $25.00 will be applied to any returned EFT pre-authorized payment.

CREDIT CARD OR ACCOUNT INFORMATION

CREDIT CARD INFORMATION

VISA MASTERCARD DISCOVER AMERICAN EXPRESS

CARD HOLDER NAME: _____

CREDIT CARD #: _____

EXP. DATE _____/_____ AUTHORIZATION CODE: _____ ZIP CODE: _____

BANK ACCOUNT INFORMATION

ACCOUNT HOLDER(S) NAME(S): _____

ACCOUNT #: _____

PATIENT NAME: _____

RESPONSIBLE PARTY: _____

_____ _____/_____/_____
ACCOUNT HOLDER'S SIGNATURE DATE