

ACH Debit | Authorization Form



Frank Batastini Orthodontics Payment Plan Authorization

Name: _____
Please print First Middle Last
Address: _____ Date of Birth: _____
City/State/Zip: _____ Last 4 digits of Social Security #: _____
Home Phone: (_____) _____ Driver's License #: _____
Work Phone: (_____) _____ Driver's License State: _____

Payment Plan Schedule

One-time Payment Payment Amount: \$ _____ Payment Date: _____

Recurring Debit every: _____ Day(s) Week(s) Month(s)

Start Date: Month: _____ Day: _____ Year: _____ Payment Amount: \$ _____
(Start date must be at least 15 business days from submission of this form)

End Date: Month: _____ Day: _____ Year: _____ Transaction Fee: \$ _____

Number of Payments: _____ Total Payment: \$ _____
(Payment Amount + Transaction Fee)

Customer Bank Account Information

Bank: _____ Phone Number: (_____) _____
Routing Number: _____
Account Number: _____

Attach a voided check to this form.

Payment Authorization

I authorize my bank to debit my account as identified above to the terms stated here. This authorization shall remain in effect until the Service Provider and bank receive written notification from me of intent to terminate at such time and in such manner as to afford the Service Provider and bank reasonable opportunity to act (Minimum 30 days).

I understand that if the total amount owed to the Service Provider is increased, I authorize this plan to continue as long as the payment amount remains unchanged until the amount owed the Service Provider is paid off, or unless the plan is terminated earlier by me as above. I understand any added amounts can be applied for with a new ACH Debit Authorization Form.

All other changes such as payment amount, frequency, bank account number change, will require a new ACH Debit Payment Authorization Form to be filled out and submitted to Merchant 15 days prior to any change being implemented. I understand that this payment plan may be cancelled by the Service Provider or Merchant due to NSF (Non-sufficient Funds). I will be liable to pay an NSF fee of \$25.00 (or the amount allowable by law), which may be automatically debited for each NSF.

I represent and warrant that I am authorized to execute this payment authorization for the purpose of implementing this payment plan. I indemnify and hold the Service Provider, the bank, and Merchant harmless from damage, loss or claim resulting from all authorized actions hereunder.

Customer Signature: _____ Date: _____

Second Authorized Signature of Bank Account if Required: _____ Date: _____
This document was created using an EVALUATION version of ActiveReports. Only a licensed user may legally create reports for use in production. Please report infractions or address questions to powersales@grapecity.com.
Copyright © 2002-2011 GrapeCity, inc. All rights reserved.