Auto Pay Enrollment Form

Patient Name: _____

Account Number: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Checking/Savings Account Information

Name of Bank: _____

Name on Account: _____

Routing Number: _____ Account Number: _____

**The routing number is the first 9 digits in the bottom left hand corner of your check. Please do not include check number.*

Credit Card Information

Credit Card Number: _____ Exp Date: _____

Cardholder Name: _____

Auto Pay Plan Information

Please deduct payment in the amount of: _____

Please deduct payments: Monthly _____ Bi-Monthly _____ Weekly _____

Please deduct payment on: _____

**Payments must be made by the 25th of each month. If payment date falls on a weekend or holiday, the payment will be deducted on the following business day.*

Please deduct payments for: _____ (# of months)

I acknowledge the debit to my account will reflect OrthoSynetics, Inc. as the creditor. I authorize OrthoSynetics to automatically charge my account in the amount listed above and acknowledge this agreement will remain in effect until cancelled by myself, OrthoSynetics, or my financial institution. I can cancel my agreement at any time by calling or writing to **OrthoSynetics, 3850 North Causeway Blvd., Ste. 800, Metairie, LA 70002, (866) 255-1016.**

A service charge will be applied to any returned EFT pre-authorized payment.

Signature _____ Date _____

For processing, please fax to (504) 834-3189. Please note that your monthly charge will reflect OrthoSynetics on your monthly bank statement or credit card invoice.

3850 N. Causeway Blvd. Suite 800 Metairie, LA 70002 P: 888.255.1016 F: (504) 834.3189