Auto Pay Enrollment Form

Patient Name: _____

Address:_____ City:_____ State:_____ Zip:_____

Bank Account Information

Name of Bank:_____ Name on Account:_____

Routing Number:_____ Account Number:_____

Credit/Debit Card Information

Card Number:_____ Expiration:_____

CCV:_____ Billing Zip Code:_____

Cardholder Name:_____

Auto Pay Agreement

Monthly Payment: $_____ Payment Date:_____ (1st through 25th)

Payments will be deducted monthly until contract is paid in full. If payment date falls on a weekend or holiday, the payment will be deducted on the following business day.

I authorize Timothée Orthodontics to charge my account as stated above. This agreement will remain in effect until I or the Payee terminate it.

Signature:_____ Date:_____