



PAYMENT AUTHORIZATION FORM

Schedule your payment to be automatically deducted from your bank account, or charged to your Visa, MasterCard, American Express or Discover Card. Just complete and sign this form to get started!

How Recurring Payments Work:

You authorize regularly scheduled charges to your checking/savings account or credit card. You will be charged the amount indicated below each billing period. A receipt of each payment will be emailed to you and the charge will appear on your bank statement as an "ACH Debit".

I, _____ authorize Goshgarian Orthodontics to charge my bank account, debit/credit card indicated below for the recurring payment.

Patient Name: _____
 Billing Address: _____
 City, State, Zip: _____
 Phone #: _____
 Email: _____

Charges will be processed on the 1st or 15th of each month.

Checking Savings

Visa MasterCard Amex Discover

Name on Account _____
 Bank Name _____
 Account Number _____
 Bank Routing # _____
 Bank City/State _____

Cardholder Name _____
 Card Number _____
 Exp. Date _____
 CVC Code _____



SIGNATURE _____ DATE _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify **Goshgarian Orthodontics** in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. For ACH debits to my checking/savings account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Non Sufficient Funds (NSF) I understand that **Goshgarian Orthodontics** may at its discretion attempt to process the charge again within 30 days. If payment on any credit/debit card or bank account fails to process on the selected date and Goshgarian Orthodontics is not notified with updated information, Goshgarian Orthodontics will apply a **\$28.00** late fee if payment is not made before the next billing cycle. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank or credit card company; so long as the transactions correspond to the terms indicated in this authorization form.

For Office Use Only

\$ _____ Monthly, commencing _____ for a total of _____ months.