OPTIONAL – AUTO PAY FORM

FOR OFFICE USE: PATIENT # _____ EFFECTIVE DATE OF AUTHORIZATION _____

TYPE OF AUTHORIZATION:

☐ New Change: ☐ Payment amount ☐ Payment Date ☐ Banking Info ☐ Discountinue

When you receive your monthly statement, you have until the last business day of each the month to make your payment, after which a late fee of $25 is applied to your account for missed/late payment until account is brought current.

For payments, you can come in to our office, call us on the phone to run a credit card, or go online to lufforthodontics.com and navigate to >For Patients >Financial Options.

Optionally, auto pay is available as a courtesy to make your life easier! It is convenient and your payment will always be on time, eliminating late charges. Please complete all the information on the form below to begin your recurring payments.

I FULL NAME authorize Luff Orthodontics to charge my account indicated below for the payment of my/my child(s) orthodontic treatment on the 1ST-25TH of each month.

PATIENT NAME

BILLING AMOUNT

BILLING ADDRESS

PHONE #

CITY, STATE, ZIP

EMAIL ADDRESS

☐ CHECKING ☐ SAVINGS

NAME ON ACCOUNT

BANK NAME

ROUTING #

ACCOUNT #

BANK CITY/STATE

NON-REFUNDABLE $30 FOR NSF
VOIDED CHECK REQUIRED PRIOR TO START

☐ VISA ☐ MC ☐ AMEX ☐ DISCV

CARDHOLDER NAME

CARD # ---- ---- ---- ----

EXP DATE XX/XXXX

CVV

BY SIGNING THIS FORM YOU ARE ACCEPTING TEXT MESSAGES FOR DECLINED PAYMENTS.

NON-REFUNDABLE NSF $30 FEE ON DEBIT CARDS

SIGNATURE

DATE

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the above named business in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fail on a weekend or holiday, I understand that the payments may be executed on the next business day. 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debits to my checking/savings account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates.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 the above named business may at its discretion attempt to process the charge again within 30 days and agree to an additional charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. 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.