MITCHELLORTHODONTICS
George T. Mitchell DDS

AUTO DRAFT/CHARGE AUTHORIZATION

Patient Name: _____ Patient #: _____

To initiate or renew Auto Draft, simply complete this Authorization Form. Please allow ten (10) business days for processing.

The initial debit will begin on the 1st _____ or 15th _____ of the month, year _____.

Payments will be deducted from your account on your next scheduled payment due date: however, if it falls on a weekend or holiday, it will be deducted on the next business day. Sufficient funds must be in your account using debit card for payment. If your payment is not honored due to insufficient funds, you will be charged a $30.00 insufficient funds fee. Two insufficient funds within 12 months may result in the termination of your auto draft. You will not receive a monthly statement from Mitchell Orthodontics as long as your account is in repayment and is current. To cancel or change your payments, we must receive written notification at least ten (10) business days prior to the payment due date to allow for processing.

I authorize you, George T. Mitchell DDS/Mitchell Orthodontics, to charge my account to cover my monthly orthodontic payments. I agree that any payments not honored are my responsibility. George T. Mitchell, DDS/Mitchell Orthodontics will not incur any liability or expenses as a result of these actions. I also understand it is my responsibility to notify Dr. George T. Mitchell, DDS/Mitchell Orthodontics of any changes regarding this account.

Monthly Payment Schedule $_____ for _____ months.

To begin _____ and to end _____.

Please check one: ( )Debit/Check Card ( )Visa ( )Mastercard ( )American Express ( )Discover

Name of financial institution: _____

Account Holder Name: _____ CV Code: _____

Account Number: _____ Exp Date: _____

Address: _____ City _____ State: _____ Zip: _____

_____ Date: _____
Signature of Account Holder