WATTERWORTH ORTHODONTICS, PA
AUTHORIZATION AGREEMENT FOR DIRECT PAYMENTS (ACH DEBITS)

I hereby authorize Watterworth Orthodontics, PA to initiate direct payments to my

☐ Checking Account / ☐ Savings Account (select one)

Indicated at the financial institution named below, and to debit the same to such account. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law.

Financial Institution Name:_____ Name as it appears on the account _____

Routing Number:_____ Account Number:_____

☐ Business ☐ Personal

Please provide a VOIDED CHECK.

This authority is to remain in full force and effect until Watterworth Orthodontics, PA has received written notification of its termination in such time and in such manner as to afford Watterworth Orthodontics reasonable opportunity to act on it, minimum 10 days prior to my scheduled draft**. This arrangement, including the withdrawal date will not be altered without a new ACH form being completed by the responsible party.**

Amount of Total Withdrawal	Monthly Payment Amount	Final Payment Amount	Total Number of Monthly Withdrawals	Withdrawal Begin Date		
				Month	Day	Year
					1 or 15	

The above "Amount of Total Withdrawal" is not the total fee for treatment, but rather indicates the portion allocated to direct drafts. If I have insurance, I also authorize any additional ACH Debits to reconcile the estimated insurance with the actual insurance payments. I further agree that if funds are not available in my bank account (NSF, closed account, etc) a $35 fee will be charged. The name "Watterworth Orth Xcharge" will appear on my monthly statement.

Responsible Party Name:
Patient Name:

Date:_____ Signature:_____

SSN: _____