Repetitive ACH Authorization

☐ New Payment Plan ☐ Change an Existing Plan

PATIENT/CLIENT NAME	PATIENT/ACCOUNT ID

RESPONSIBLE PARTY (Name on the checking account)

NAME (FIRST-MIDDLE-LAST)	SOCIAL SECURITY NUMBER
	- -
HOME PHONE ( )	EMAIL ADDRESS

FINANCING INFORMATION: Monthly payment will be paid directly from your bank account.

BALANCE DUE	PAYMENT	TRANSACTION FEE	TOTAL PAYMENT	PLEASE CHECK BOX FOR YOUR PAYMENT DATE(S)	START DATE
		+ $2.50 =		☐ 3RD ☐ 10TH ☐ 18TH ☐ 25TH	

"I hereby agree to the 'Terms & Conditions' shown below and authorize the automatic debiting of my bank account according to the above payment schedule until the 'Balance Due' shown above is paid in full. **I agree to provide notice of any change to my bank information at least 1 week in advance of the next payment date.**"

SIGNATURE OF RESPONSIBLE PARTY	DATE

EITHER ATTACH VOIDED CHECK *OR* LIST BANK INFORMATION BELOW. (Do NOT use a deposit slip!)

Bank Name_____ Phone _____

Bank Address_____ _____

City_____ State _____ Zip _____

☐ Checking Account ☐ Savings Account Check # (from sample check)_____

BANK ROUTING NUMBER:	ACCOUNT NUMBER:

TIPS TO IDENTIFY ROUTING AND ACCOUNT NUMBERS:

There are three sets of numbers along the bottom line of your check the Bank Routing Number, the Account Number, and the check number The easiest way to identity each of these is through the process of elimination. First, eliminate the check number. This will leave the Routing number and account number The [: symbols will always be at the beginning and end of the 9 digit Routing Number. The account number is what is left over and will be anywhere from 5 to 16 digits

⑆123456789⑆ 1234 123456789?

Bank Routing Number Always 9 Digits | Check Number | Account Number 5-16 Digits

FAX COMPLETED FORM TO 800-481-0946

TERMS AND CONDITIONS

DOCPAY is a trade name of Complete Systems, Inc. and has been authorized by the Doctor's Practice to administer this payment plan The transaction fee indicated above is applied each time the Responsible Party's account is debited. Should there be insufficient funds in the account, additional debits may need to be processed. **There is a return charge of $10.00 for all returned items.** Upon default of the above payment schedule due to Insufficient funds withdrawal of the authorization, nonpayment or bankruptcy, the entire unpaid balance may, at the option of the Doctor's Practice, be declared immediately due and owing. In such cases Responsible Party agrees to pay the reasonable cost of collection and/or attorneys fees as permitted by the governing laws of the state. Neither the Practice, Depository nor Complete Systems, Inc. is liable for any incidental or consequential damages stemming from the transfer of funds unless due to fraud or willful misconduct. Responsible Party should receive a monthly statement from the above listed bank showing funds transferred. DOCPAY does not collect insurance payments.

REQUIRED INFORMATION - PAY PLAN CANNOT BE PROCESSED WITHOUT THIS!

PRACTICE NAME **(REQUIRED)**	PRACTICE I.D. CODE	PHONE # **(REQUIRED)**

Your monthly payment will appear on your bank statement showing **DOCPAY ACH** as the payee.

In the event a payment is rejected or returned unpaid, a $10.00 NSF fee will be added to your account.

If you change your bank account, you must notify Practice at least one week prior to your next payment date.

For account changes or any other questions regarding your account please call your practice.

FORM DISTRIBUTION- MAKE COPY FOR PATIENT - Keep a copy in patient chart – Fax to DOCPAY