Dr. Richard Byrd & Associates
ORTHODONTICS

9221 Forest Hill Avenue
Richmond, VA 23235
(804) 330 – 0508

2929 Polo Parkway
Midlothian, VA 23113
(804) 379 - 3718

Request for Automatic Bank Draft

This Account is: Checking [ ] Savings [ ]

Name of the person responsible for payment: _____

Routing Number (9 digits): _____ Account Number: _____

Bank Name: _____ **ATTACH A VOID CHECK or DEPOSIT SLIP**

Day of the Month (Circle One) **1st** **15th** **28th**

Total Amount Initially Financed of _____, will be collected in monthly installments of _____, for an estimated _____ months.

I have given authority to the above named bank to honor preauthorization checks drawn by Richard L. Byrd, DDS, PC. When the bank honors the check, such check shall constitute by receipt for payment.

I understand that I will be responsible for a $45 fee for any draft not honored by my bank for any reason and any resulting late fees as a result of dishonored payments. This authorization is in effect until I notify Dr. Richard L. Byrd, DDS, PC otherwise in writing.

By signing this authorization, I acknowledge that I have read and agree to all of the above information and warrant all information provided is true and correct.

THIS AGREEMENT REMAINS IN EFFECT UNTIL CANCELLED BY THE APPLICANT WITH WRITTEN NOTICE or until services have been paid for in full. This agreement may be cancelled by the applicant by providing Dr. Richard L. Byrd, DDS, PC a written notice at least 30 days in advance of cancellation date.

_____ _____

Applicants Signature Date

_____ _____ _____

Patients Name Patients Date of Birth Acct #