Dental Care Alliance
STRONGER TOGETHER

Reset Form

MONTHLY RECURRING PAYMENT PLAN

PATIENT NAME | PATIENT DATE OF BIRTH | RESPONSIBLE PARTY

STREET ADDRESS | CITY | STATE | ZIP

Please select the primary and secondary accounts Dental Care Alliance, L.L.C. is to debit:

PRIMARY

☐ Credit Card

Visa ☐ MasterCard ☐ Discover ☐ - (AMEX not available)

** _____
Name(s) as it appears on your account

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ ☐☐–☐☐ ☐☐☐

CARD NUMBER | EXPIRATION DATE | 3-DIGIT SECURITY CODE ON SIGNATURE PANEL*

* The 3-digit security code is located on the back of your card within the signature panel.

☐ Checking* ☐ Savings*

*** Copy of check or bank letter must accompany form**

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ ☐☐☐☐☐☐☐☐☐

BANK ACCOUNT # | ROUTING #

SECONDARY

☐ Credit Card

Visa ☐ MasterCard ☐ Discover ☐ - (AMEX not available)

** _____
Name(s) as it appears on your account

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ ☐☐–☐☐ ☐☐☐

CARD NUMBER | EXPIRATION DATE | 3-DIGIT SECURITY CODE ON SIGNATURE PANEL*

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☐ Checking* ☐ Savings*

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☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ ☐☐☐☐☐☐☐☐☐

BANK ACCOUNT # | ROUTING #

MONTHLY INSTALLMENTS

I hereby authorize Dental Care Alliance, L.L.C. (hereinafter "Dental Care Alliance") on behalf of the dental practice, to initiate debit entries and if necessary, credit entries for any adjustments, to the account(s) indicated above via electronic funds transfer (EFT) in the amount of:

Select Withdrawal Start Date

☐ 1 ☐5 ☐10 ☐15 ☐20 ☐25

Month:_____ Year: 20____

Monthly Payment Amount: $_____.____

Number of Equal Monthly Withdrawals: (x) _____

Amount of Total Withdrawal: (=) $_____.____

I hereby authorize the financial institution(s) listed above to accept and honor electronic funds transfer (EFT) withdrawals by Dental Care Alliance. I understand and authorize that starting on the date set forth above, Dental Care Alliance will commence withdrawals from my bank or credit card account and that such withdrawals will continue each month until the entire balance, provided to Dental Care Alliance by the dental practice, is paid in full. I understand that Dental Care Alliance is debiting funds from my bank or credit card account for payment to the dental practice, for professional services provided. I further understand and agree that should Dental Care Alliance be notified that funds are not available in my bank account or that a charge to my bankcard is denied, a $20 fee will be charged by Dental Care Alliance. I understand and agree that if funds are not available from the account I select as primary, Dental Care Alliance can attempt to secure funds from the account I select as secondary, and that if no secondary account is selected, Dental Care Alliance can re-draft my primary account. This authorization is to remain in full force and effect until the entire balance, provided to Dental Care Alliance by the dental practice, has been paid in full or Dental Car e Alliance has received written notification of its termination in such time and in such manner as to afford Dental Care Alliance a reasonable opportunity to act on it.

** _____ _____

SIGNATURE OF ACCOUNT/CARD HOLDER | DATE

***FOR OFFICE USE ONLY**

Location # 5 3 2 0 1 Location Name ASHCRAFT-LR Clinic☐☐☐ Doctor#☐☐☐

Patient # ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

*** Regional Managers Approval (Non-Ortho Transactions only)** _____

Form updated 8/14/18