Beam Orthodontics
1000 Main Street
Penticton, BC V2A 5E5
250.493.4118

PRE-AUTHORIZED DEBIT AGREEMENT FORM

CUSTOMER INFORMATION

PATIENT NAME: _____RESPONSIBLE PARTY: _____

ADDRESS: _____

CITY/PROVINCE/POSTAL CODE: _____

PHONE NUMBER: _____ ALTERNATIVE PHONE NUMBER: _____

BANK ACCOUNT INFORMATION – Provide Pre-authorized bank form, void cheque or fill out information below

NAME ON BANK ACCOUNT: _____ACCOUNT NUMBER: _____

TRANSIT NUMBER: _____BRANCH NUMBER: _____

FINANCIAL INSTITUTION NAME AND ADDRESS:

_____

PAYMENT INFORMATION

This document authorizes and instructs Dr. Jonathan P. Paxon Inc. to electronically process recurring payments from the above account on the scheduled date, indicated below, as a method of receiving regular monthly/quarterly payments for contracted orthodontic care.

These services are for (check one): Personal Use _____ Business Use _____

Beginning Date of Payments: _____

Payment Amount: _____ Payment Frequency: _____ Date of Debit: 5th or 25th

Final Payment Amount: _____Total Number of Payments: _____

I authorize the following credit card number to be used if an alternative payment method is required (e.g., NSF payment)

CREDIT CARD NUMBER: _____EXPIRATION DATE: _____

CREDIT CARD BILLING ADDRESS: _____

CITY: _____ PROVINCE: _____ POSTAL CODE: _____

SIGNATURE OF CARD HOLDER: _____DATE: _____

My entry of the information above and my signature of this agreement shall be my authorization to electronically debit my account as indicated above. If any debited item is dishonored or returned there may be a fee of $35 per returned item.

You the Payor may revoke your authorization at anytime, subject to providing notice of 30 days. To obtain a sample cancellation form, or for more information on your right to cancel a PAD agreement, contact your financial institution or visit www.cdnpay.ca.

You have certain recourse rights if any debit does not comply with this agreement. For example, you have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD agreement. To obtain more information on your recourse rights, contact your financial institution or visit www.cdnpay.ca.

SIGNATURE OF PATIENT/PARENT/GUARDIAN: _____

PRINTED NAME: _____DATE: _____