COHEN & MONTINI
ORTHODONTICS

AutoPay Enrollment Form

Patient Name: _____

Account Number: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Checking/Savings Account Information

Name of Bank: _____

Name on Account: _____

Routing Number: _____ Account Number: _____

**The routing number is the first 9 digits in the bottom left hand corner of your check. Please do not include check number.*

Credit Card Information

Credit Card Number: _____ Exp Date: _____

Cardholder Name: _____

Auto Pay Plan Information

Please deduct payment in the amount of: _____

Please deduct payment on: _____

**Payments must be made by the 5th of each month. If payment date falls on a weekend or holiday, the payment will be deducted on the following business day.*

I acknowledge the debit to my account will reflect OrthoSynetics, Inc. as the creditor. I authorize Cohen & Montini Orthodontics to automatically charge my account in the amount listed above and acknowledge this agreement will remain in effect until cancelled by myself, Cohen & Montini Orthodontics, or my financial institution. I can cancel my AutoPay service at any time by calling **Cohen & Montini Orthodontics at (352) 332-7911 or (352) 237-3366.**

A service charge will be applied to any returned EFT pre-authorized payment.

Signature _____ Date _____

(Please note that your monthly charge will reflect **OrthoSynetics** on your monthly bank statement or credit card invoice.)

Cohen & Montini Orthodontics

7520 W. University Avenue
Suite C
Gainesville, FL 32607
(352) 332-7911

3201 S.W. 34th Avenue
Suite 202/203
Ocala, FL 34474
(352) 237-3366