Payment Arrangement

Responsible Party Information

Dental Office Name	Office Number	Effective Date	Payment Plan #
FirstName	LastName	Guarantor ID	E-Mail Address
Address	City, State, Zip	Primary Phone #	

Payment Arrangement Details

Payment(s) will be processed monthly on the same day as specified under "Date Charges Begin".

Treatment Amount	Initial Payment	Balance (less initial payment)	Convenience Fee	Total Recurring Balance (including fee)	Monthly Payment Amount	Total # of Charges	Date Charges Begin
			$25.00				

Secure Payment Method(s)

Confirm Payment Methods

Primary Credit Card Number _____ **Expiration Date:** _____ **CVV Code:** _____

Secondary Credit Card Number _____ _____ **Expiration Date:** _____ **CVV Code:** _____

CREDIT/DEBIT CARD CHARGE AUTHORIZATION

Authorization: I hereby authorize the Dental Office to charge the account(s) indicated above via credit/debit card charge. I hereby authorize the financial institution(s) named above to accept and honor credit card charges from the Dental Office.

Terms: I understand that beginning on the date of the first payment as indicated above, the Dental Office will begin charges from my designated account above or if the Dental Office is unable to secure payment from that account then the Dental Office may charge the Backup Card. Such withdrawals or charges will continue each month until the entire Payment Arrangement Balance is paid in full. I understand my statement will reflect “Wellfit*Dental Office” as the merchant alongside the charges.

Fees: I agree to pay the Dental Office a $25.00 convenience fee at the time I enter into this recurring payment authorization. This fee will be used to administer the recurring payment processing. This recurring payment authorization is not an extension of credit, and there are therefore no finance charges imposed in connection with this agreement.

No Interest and No Prepayment Penalty: No interest accrues on this payment plan. The Monthly Payment is calculated as the Treatment amount, less Initial Payment, plus Convenience Fee divided by the Total Number of Charges. There will be no penalty for paying the amount prior to the due date.

Declined Payments: In the event the Dental Office is notified that a charge to my credit card account is denied, I agree and authorize the Dental Office to make up to two additional attempts to resubmit for payment, without advance notification to me, provided such resubmission attempts occur within 15 business days of the originally scheduled payment date No additional fee will be charged as a result of such resubmission attempt.

Default of this Agreement: I understand that the Dental Office is extending credit to me on the basis that I abide by the terms of this agreement. In the event that payment is not received on the date it is due, it will constitute a default of this agreement, and the entire remaining unpaid balance will be immediately due and payable in full. At that time any and all collection attempts permitted by law may be made if payment is not received. This default condition does not apply to authorizations set up for more than 4 months.

Manual Payment in Place of Automated Payment: I understand that I have voluntarily set up automated, recurring payments and that if I choose to make a payment to the Dental Office directly in place of my automated, recurring payment, I will do so no later than five (5) business days in advance of the scheduled pay date to allow time to cancel the next scheduled recurring payment. If my manual payment is made directly to the Dental Office less than five (5) business days in advance of my next scheduled pay date, I understand that I may run the risk of being double-charged and that a credit to my designated account for the duplicate payment will be processed as soon as possible but may not be immediate. In all cases, the Dental Office will not be responsible for any fees or charges resulting from duplicate payment. I understand that a refund will be issued if I request it. If a refund is not requested and no other changes have been made to this arrangement, I understand the duplicate payment will be credited toward my remaining balance.

Agreement: By signing below, I agree to the Payment Arrangement Plan terms above, and I acknowledge that I will receive a copy of the Payment Arrangement Plan terms for my records.

Signature:

Date: