Payment Plan Authorization Form

You can pay off your balance with a simple automated payment plan. It's easy to set-up, and your payments will take care of themselves. Just complete and sign the form below to get started!

Please complete the information below:

Total Due: $3950 -355 registration fee =$3595 Payment Frequency: Weekly

# of Payments: 10 Start Date: _____

Payment Amount: $359.50

I _____ authorize Center for Advanced Dental Assisting to charge my account indicated
(full name)

below to discharge the above debt for _____, using installment
(description of goods/services)

payments in the amount and schedule indicated.

Billing Address _____ Phone# _____

City, State, Zip _____ Email _____

Credit Card

☐ Visa ☐ MasterCard

☐ AMEX ☐ Discover

Cardholder Name _____

Account Number _____

Exp. Date _____

CVC Code _____

SIGNATURE _____ DATE _____

I understand that this authorization will remain in effect until the debt is fully discharged or I cancel it in writing whichever comes first, and I agree to notify the business in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment date falls on a weekend or holiday, I understand that the payment may be executed on the next business day. For ACH debits to my checking/savings account, I understand that because this is an electronic transaction, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Non Sufficient Funds

(NSF) I understand that Center for Advanced Dental Assisting may at its discretion attempt to process the charge again within 30 days, and agree to an additional $30 charge for each attempt returned NSF, which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card/bank account and will not dispute Center for Advanced Dental Assisting billing with my bank or credit card company; so long as the transaction corresponds to the terms indicated in this agreement.