Ballard Family Chiropractic

Automatic Draft Agreement

Payment Options (Choose one)

☐ Pay balance **IN FULL**

☐ Monthly autopayment (please fill out the remaining info below)

Credit/Debit Card Info

☐ Visa

☐ Mastercard

☐ Discover

Draft Date

☐ 1st

☐ 12th

☐ 24th

Amount of Monthly Draft:_____ for _____ months

Card Number: _____ Exp: _____/_____ Code:_____

Name on Card:_____

By signing this form, I hereby authorize Ballard Family Chiropractic to make automatic drafts to the account listed above, on the 1st, 12th, or 24th of each month. I understand that beginning on the date listed above, Ballard Family Chiropractic will begin automatic drafts and they will continue each month until my balance is paid in full. These funds will be used to pay for products or services rendered and *will never exceed the current balance on my account.* This authorization shall remain in force until I cancel the auto draft service with a written notice. I understand that cancellation does not negate my responsibility to pay for the services or products I have been provided.

Signature: _____ Date:_____

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