Current Balance $ _______________

AUTOMATIC DRAFT AGREEMENT

Payments will be charged/withdrawn until there is a zero balance on your account. Any changes to this agreement (card #, etc.) must be submitted in writing to Jernigan Surgery Clinic, PLLC.

Please choose either a credit card charge or bank account withdrawal for your payment plan. Fill out only one section below.

CREDIT CARD

Account #: _______________________________________ Exp Date: __________

Name on Account: _________________________________ CVV: _____________

Cardholder Address: _________________________________ Zip: _____________

Charge my card $_________ every □ 2 weeks □month *(check one)*

First payment to be charged on *(enter date)*: ___________________

BANK ACCOUNT

(please provide a voided check)

□ Checking Account □ Savings Account *(please select one)*

Account #: ______________________Bank Routing #: ______________________

Name on Account: ____

Account Owner Address: _______________________________ Zip: ___________

Withdraw $_________ every □ 2 weeks □month *(check one)* from my account

First payment to be withdrawn on *(enter date)*: ___________________

I authorize Jernigan Surgery Clinic, PLLC to make the above charges/withdrawals from my account as detailed above.

___________________________	_________________________	___/___/___
Patient Name (Printed)	Patient Signature	Date