Pre-Authorized Debit Agreement

Patient/Parent Information

Account Holder's Name: ____

Address: ____

City: ______________________________ Province: ________________ Postal Code: _____________

Telephone Number: ______________________ Email Address: ________________________________

Patient's Name: ____

Bank Account Information

Transit Number ☐☐☐☐☐☐ Financial Institution Number ☐☐☐

Account Number: ☐☐☐☐☐☐☐☐☐☐☐☐

Financial Institution: Name: ____

Address: ____

We will require a voided cheque.

Pre-Authorized Debit Details

You, the Payer, authorize Dr. Jeffrey M. Bales Dental Corporation to debit the bank account identified above for

$ __________ monthly on the 1st , 7th, 15th or 21st, beginning on _________________________ or the next business day.

This preauthorization agreement is for a Business ☐ or Personal ☐ expense.

Number of Payments: __________

You, the Payer, may revoke your authorization at any time in writing subject to providing notice of 10 days. To obtain a cancelation form, or for more information on your right to cancel a PAD agreement, contact your financial institution or visit www.cdnpay.ca

Signature of Account Holder:

____

Name: ___________________________
(Please Print)

Date: ___________________________

Signature of Joint Account Holder (if Applicable):

____

Name: ___________________________
(Please Print)

Date: ___________________________

You have certain recourse rights if any debit does not comply with this agreement. For example, you have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD Agreement. To obtain more information on your recourse rights, contact your financial institution or visit www.cdnpay.ca.

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