

Electronic Funds Transfer Agreement for Gilden Family Chiropractic

Last Name _____ First Name _____

DOB ____/____/____ SS# ____-____-____ E-mail _____

Address _____ Apt# _____

City _____ State _____ Zip _____

Ph# home (____) ____-____ Ph# mobile (____) ____-____

Name & ph# of who referred you _____ Ph# home (____) ____-____

Monthly electronic transfer: <u> </u> \$69 signed member only <u> </u> \$89 Family plan (2 adults)
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Family plan information only:		
Sub Member Name:	DOB: / /	PH#:() -

I authorize the withdrawal of monthly payments from the below account by Gilden Family Chiropractic (“GFC”), in accordance with the terms herein. I understand that this is an open-ended contract and will automatically renew month to month unless canceled. I further understand that it is my responsibility to submit any changes or cancellations in writing 30 days prior to an adjustment of the account. It is agreed that the cancellation date will be 30 days after the written notice of cancellation is received, even if such cancel date would exceed a 30-day notice. It is also agreed that there will be no prorating of the final month of payment. I understand that the monthly fees will continue to accrue until 30 days after written notice of my cancellation is provided to GFC. A \$25.00 service fee will automatically be assessed to the account for insufficient funds or missed payments. Further, missed payments will be resubmitted and subject to an additional \$25 service fee if funds are not received. A service fee of 1.5% per month, 18% APR, will be added to all overdue accounts. I further agree that I will be liable for all legal and collection fees at the rate of 40% of the total fees and costs owed to GFC. I also understand that this is an educational membership intended to help me better understand Wellness Chiropractic and not for treatment, diagnosis, or care of a disease or for the elimination of any symptoms including but not limited to back or neck pain. It is also understood that a rotation of different doctors and or educators will be available to me during the hours of operation, which may be subject to change. Furthermore, I am aware that there will be no refunds due to lack of attendance.

Signature _____ **Start Date** ____/____/____

<i>To be filled out only if voided check is not available Place voided check here</i>	
Bank Name _____	Bank Ph# ____-____-____
ABA# _____	Account# _____
____ Checking	____ Savings