

## Automatic Monthly Debit Enrollment Form

Dermalase/Kathryn J. Wood, M.D. 3550 Parkwood Blvd., Suite 205 Frisco, Tx. 75034

### Terms of Auto Monthly Set-Up

\_\_\_ I authorize a monthly automatic debit on the account specified below (check one)

\_\_\_ \$73 per month, 12 months auto debit period (20 units quarterly)

\_\_\_ \$147 per month, 12 months auto debit period (40 units quarterly)

\_\_\_ \$220 per month, 12 months auto debit period (60 units quarterly)

\_\_\_ I understand this is for a 12 month enrollment period.

\_\_\_ I authorize a \$25 payment for all dishonored debit charge backs.

### Terms of Auto Monthly Termination

\_\_\_ I understand a 30 day written notice is required in order to terminate my automatic monthly debit transaction enrollment. Without written notice, the contract will continue, uninterrupted.

\_\_\_ I agree to mail my written notice to: Dermalase 3550 Parkwood Blvd., Suite 205 Frisco, Tx. 75034

\_\_\_ I understand my last payment will be charged on my regular payment date within 30 days of receipt of written notice of cancellation.

### Other

\_\_\_ I understand if my needs exceed the dollar amount drafted, I will need to pay the difference of \$11 a unit the day of service.

\_\_\_ I understand if I require less than the amount drafted, a credit will be put onto my account for the difference and may be used on future treatments or products.

\_\_\_ I understand no refunds will be given, my account will instead be credited.

**By Signing Below I understand, acknowledge and agree to all the terms and conditions listed above.**

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Signature

Printed Name

Date

Credit/Debit Card Type: \_\_\_\_\_ Account# \_\_\_\_\_

Expiration Date: \_\_\_\_\_ CVV2: \_\_\_\_\_ Billing Zip: \_\_\_\_\_

