Cape Coral Pet Vet

PET WELLNESS RECURRING PAYMENT PLAN

Company Name: Cape Coral Pet Vet (hereinafter referred to as "The Provider")

Section I Responsible Party Information				
Name: (Must match signature below)			Date Of Birth:	
Address			City, State, Zip	
Home #	Work #	Cell#	E-mail	
I.D. Type (ex: Driver's License, Passport, etc).		I.D. Location (ex: State, Country, etc.)		I.D. Number

*If there is more than one responsible, each Responsible MUST complete a Recurring Payment Plan Form.

Section II Account/Payment Method				
Account ID	Frequency	Start Date	Payment	Total Amount
		_____/_____/_____		

Payment Method

☐ Checking
☐ Savings
☐ Credit Card

_____ Name On Account

_____ Account Number

_____ Routing # or Expiration Date

*A $5.00 **missed payment fee** will be automatically assessed to your account by The Provider for each payment attempt that is missed.

I hereby authorize **Cape Coral Pet Vet** (hereinafter "**The Provider**"), to initiate debit entries to the account(s) (of which I am an authorized signer) indicated in Section II above via the electronic funds transfer (EFT). I understand and agree to the terms and conditions below.

Beginning on the date listed, **The Provider** will withdraw from my bank account or credit card account either (1) the payment listed above, or (2) an amount indicated on an invoice or statement sent to me by The provider at least ten (10) calendar days prior to the date my account is to be debited. Such withdrawals will continue until the total amount owed to **The Provider** is paid in full or until the recurring draft has been stopped by **The Provider** or by me. Debits will be withdrawn on the same day of your signup, every month (ex: the 12th of each month) unless it falls on a weekend, holiday, other non-business day, or otherwise agreed upon, in which case the debit will be withdrawn the next business day. **The Provider** is debiting funds from my account for payment for Pet Wellness and the name of The Provider may/will appear on my monthly bank statement.

I further agree that should **The Provider** be notified that funds are not available in my bank account (NSF, closed account, etc.) or that a charge to my bankcard is denied, a $5.00 fee will be charged by **The Provider**. I agree that if funds are not available from the account(s) listed above **The Provider** can reattempt to draft my account(s). I understand that if I choose to discontinue this method or payment, I must notify **The Provider** a minimum of 7 days prior to my scheduled debit date. Furthermore, The **Provider** may utilize an authorized third party vendor to regularly debit payments for my account using the above payment method, provided I am given reasonable notice and the payment terms have not materially changed. I also authorize The Provider to contact me at any of the telephone numbers listed above.

Signature: _____ Date: _____

For Company use only	Confirmation (Employee Initials):	Date Received