NHDL
PARTNERS IN PURSUIT OF PATIENT SATISFACTION
NEW HORIZONS DENTAL LABORATORY

If you would like to utilize the e-payment option please fill in the details below and return to us at your earliest convenience. There is no additional cost associated with this service.

I _____ (printed name of authorized person) representative of _____ (name of dental office) authorize 5280 Technologies Inc. dba: New Horizons Dental Laboratory to initiate either an electronic debit or to create and process a demand draft against my bank account according to the terms outlined below. I acknowledge that the origination of ACH transactions to my account must comply with the provisioning of United States law.

Billing Terms

Please select one set of billing terms below and enter the date and amount fields.

_____ *This **one time** on _____ [mm/dd/yy] for the amount owed to New Horizons Dental Laboratory as detailed in the Monthly Statement or Invoice # _____.*

_____ *Starting on _____ [mm/dd/yy] and on the____ [day] of each month for the amount owed to New Horizons Dental Laboratory as detailed in the Monthly Statement.*

_____ *Starting on _____ [mm/dd/yy] and subsequently debited at any time for the amount owed to New Horizons Dental Laboratory as detailed in _____ [Invoice #/#'s].*

My bank account information is as follows:

Routing Number (9 digits): _____

Account Number: _____

Bank Account Type

__ *Checking*

__ *Savings*

__ *Business Checking*

This payment authorization is to remain in full force and effect until I, _____ notify New Horizons Dental Laboratory of its cancellation by sending written notice in such time and in such manner to allow both the New Horizons Dental Laboratory and receiving financial institution a reasonable opportunity to act on it.

_____ *[Customer Signature]*
_____ *[Customer Printed Name]*

_____

[Date Signed]

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