

AUTHORIZATION FORM

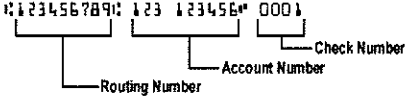
Cassidy Orthodontics

ES13798

FOR OFFICE USE ONLY	PATIENT #:	DATE:
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Effective date of authorization: ____/____/____	Name of patient: _____
Type of Authorization Form: <input type="checkbox"/> New Authorization <input type="checkbox"/> Change banking information <input type="checkbox"/> Change payment amount <input type="checkbox"/> Discontinue electronic payment <input type="checkbox"/> Change payment date	

Last Name	First Name	
Address		
City	State	Zip

Please debit payments from my (check one): <input type="checkbox"/> Checking Account (staple a voided check below) <input type="checkbox"/> Savings Account (contact your financial institution for Routing #)	Routing Number: _____ <i>Valid Routing # must start with 0, 1, 2, or 3</i> Account Number: _____ 
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DOWN PAYMENT (leave blank if not applicable) Date for withdrawal: ____/____/____ Amount of down payment: \$ _____	MONTHLY PAYMENT Date for monthly withdrawal (please check one): <input type="checkbox"/> 1 st <input type="checkbox"/> 15 th <input type="checkbox"/> Other ____ Date of first payment: ____/____/____ Date of last payment: ____/____/____ Amount of monthly payment: \$ _____ Amount of last payment: \$ _____ Total number of payments: _____
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AGREEMENT	
I authorize the above practice and Vanco Services, LLC to process debit entries to my account. I understand that this authority will remain in effect until I provide reasonable notification to terminate the authorization.	
Authorized Signature: _____	Date: _____

