AUTHORIZATION FORM

Practice Name: _____

FOR OFFICE USE ONLY	PATIENT #:	DATE:

Effective date of authorization: _____/_____/_____

Type of authorization: ❑ New authorization ❑ Change payment amount ❑ Change payment date
❑ Change banking information ❑ Discontinue electronic payment

Last name: _____ First name: _____

Address: _____

City: _____ State: _____ Zip: _____

Email address: _____

DOWN PAYMENT: (leave blank if not applicable)

Date for withdrawal: _____/_____/_____ Down payment amount: $_____

MONTHLY PAYMENT:

Date for monthly withdrawal (please check one): ❑ 5th ❑ 20th

Date of first payment: _____/_____/_____ Date of last payment: _____/_____/_____

Amount of monthly payment: $_____ Amount of last payment: $_____ Total number of payments: _____

CHECKING / SAVINGS

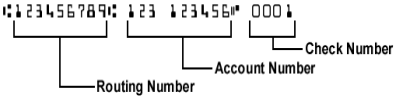
Please debit payment from my (check one):

❑ Savings Account (contact your financial institution for Routing #)

❑ Checking Account (staple a voided check below)

Routing Number: _____
Valid Routing # must start with 0, 1, 2, or 3

Account Number: _____



I authorize the above practice 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:_____

CREDIT CARD

Please charge my payments to my (check one): ❑ Visa ❑ MasterCard ❑ American Express ❑ Discover Card

Credit Card Number:	Expiration Date:

Name on Card:

Billing Address (if different from above):

I authorize the above practice to charge my credit card in accordance with the information above.

Signature (as it appears on the credit card): _____ Date: _____

If using a checking account, please attach a voided check over the credit card section above.