AUTHORIZATION FORM

Cassidy Orthodontics **ES13798**

FOR OFFICE USE ONLY	PATIENT #:	DATE:

Effective date of authorization: _____/_____/_____ Name of patient: _____

Type of Authorization Form:
- ❑ New Authorization
- ❑ Change payment amount
- ❑ Change payment date
- ❑ Change banking information
- ❑ Discontinue electronic payment

Last Name	First Name	
Address		
City	State	Zip
Email Address		

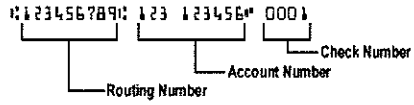
Please debit payments from my (check one):

❑ Checking Account (staple a voided check below)

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

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

Account Number: _____



DOWN PAYMENT (leave blank if not applicable)

Date for withdrawal: _____/_____/_____

Amount of down payment: $_____

MONTHLY PAYMENT

Date for monthly withdrawal (please check one): ❑ 1st ❑ 15th ❑ Other_____

Date of first payment: ____/____/____ Date of last payment: ____/____/____

Amount of monthly payment: $_____ Amount of last payment: $_____

Total number of payments: _____

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:_____

Please attach voided check here.