AUTHORIZATION FORM

Brock Orthodontics

ES8246

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		

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: _____

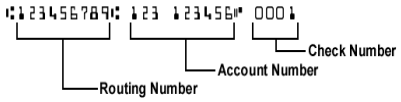
CHECKING / SAVINGS

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: _____

Please attach voided check over credit card section above if using checking account.