AUTHORIZATION FORM

PERIAGO ORTHODONTICS **ES9927**

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

DOWN PAYMENT (leave blank if not applicable)

Date for withdrawal: _____/_____/_____

Amount of down payment: **$**_________

MONTHLY PAYMENT

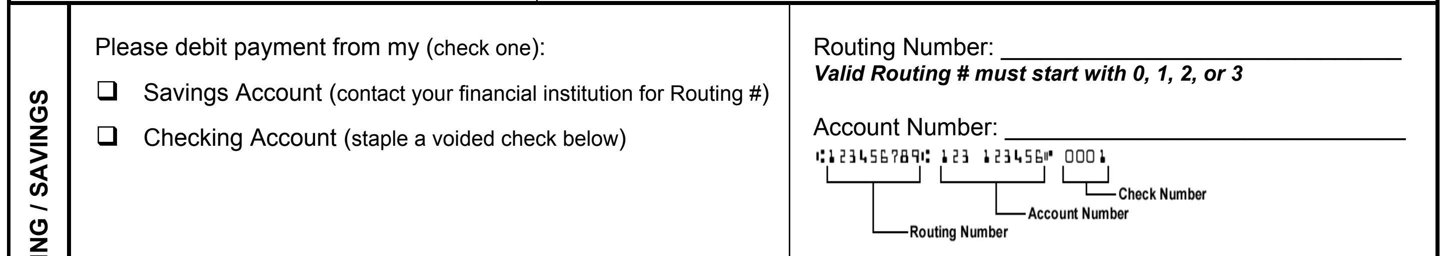
Date for monthly withdrawal (please check one): ❑1st ❑4th ❑10th ❑15th ❑25th

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.