AUTHORIZATION FORM

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FOR OFFICE USE ONLY	PATIENT #	DATE

Effective date of authorization: _____/_____/_____

Type of authorization:

- ❑ New authorization
- ❑ Change banking information
- ❑ Change payment amount
- ❑ Change payment date

Last Name	First Name	
Address		
City	State	Zip
Email Address		

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: _____

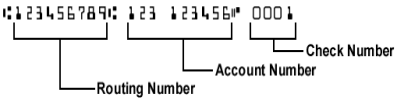
CHECKING / SAVINGS

Please debit payment from my (check one):

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

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:_____

CARDCREDIT

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: _____