AUTHORIZATION FORM

Practice Name: Shae Ochoa DDS, MS ES1527

FOR OFFICE USE ONLY	PATIENT NAME:	ACCT. #

Effective date of authorization: _____/_____/_____

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

RESPONSIBLE PARTY

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): ☐ 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):

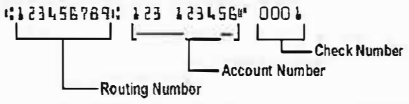
☐ Savings Account (contact your financial institution for Routing #)

☐ 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: CVC

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: _____

Phone Number: _____

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