AUTHORIZATION FORM

Practice Name: Luff Orthodontics, LLC

FOR OFFICE USE ONLY	PATIENT #	DATE

Effective date of authorization: _____/_____/_____

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

Patient's Last Name	Patient's 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: _____

⑆123456789⑆ 123 123456‖ 0001

Check Number
Account Number
Routing Number
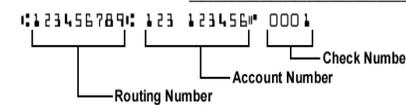
I authorize the above practice to process debit entries to my account. I understand that this authority will remain in effect until I provide reasonable notification to terminate the authorization.

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: _____

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