

Carroll & Sutton Orthodontics

BANK AUTHORIZATION FORM

Patient Name _____

Responsible Party Name _____

Client ID# _____

Effective Date _____

****AUTHORIZATION FOR ELECTRONIC PAYMENT OF VANCO SERVICES PROGRAM CHARGES****

I authorize Vanco Services, LLC to initiate DEBIT transaction to the account indicated below. This authorization will remain in effect until I notify Carroll & Sutton Orthodontics, LLC in writing to discontinue the electronic payment.

CHECKING AND SAVINGS ACCOUNT INFORMATION

Name of Financial Institution _____

Guarantor's Address: _____

City _____ State _____ Zip _____

Authorized Signature on Account _____ Date _____

Account Type Checking (attach voided check)
 Savings (attach deposit ticket or contact back for routing #)

Routing Number _____ Account Number _____

CREDIT CARD INFORMATION

Name on Card _____

Billing Address _____

Card Type Visa MasterCard Amex Discover

Card Number _____ Expiration Date _____

SPECIAL INSTRUCTION

Payments ___ / ___ / _____ - ___ / ___ / _____ \$ _____

Additional Information: