

# 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: