AUTHORIZATION FORM

Practice Name: Cody W Haslam DDS, 3307 Grand Ave #105, Billings, MT 59102 ph 406-652-7313 Fax 406-651-0713

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

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

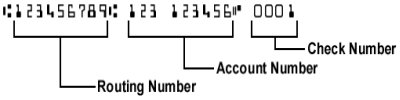
Please debit payment from my (check one):

- ❑ 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:_____

If using a checking account, please attach a voided check to the bottom of this page