Automatic Payment Authorization Form

I hereby authorize D. Iris Erdell, DDS, MS, Orthodontic office to keep my signature on file and to initiate debit entries to my (our) bank account/card listed below, at the depository institution named below, herein called DEPOSITORY, and to debit the following such account:

Please select one:

Checking Savings Visa Mastercard American Express Discover Debit

I authorize Dr. Erdell to take a ONE time payment in the amount of $__________________ for

patient____(patient name).

Name on Account:_________________________________

Address:____________________________________ City:______________________________

State:___________ Zip:______________

Credit Card Number:____ VCode:_____________

EXP Date:_______________

I (we) also understand that there will be a $35 charge for each transaction that could not be processed due to insufficient funds, changed accounts, or expired credit cards.

Name:____

Date:__________________________ Signature:______________________________________

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