

AUTHORIZATION for DIRECT PAYMENT

TYPE of AUTHORIZATION: _____ New _____ Change

PATIENT: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

MONTHLY PAYMENT (CHARGED on the 15TH of EACH MONTH)

DATE OF FIRST PAYMENT: _____ DATE OF LAST PAYMENT: _____

MONTHLY PAYMENT: \$ _____

CHECKING/SAVINGS:

_____ SAVINGS (contact your financial institution for ROUTING #)

_____ CHECKING (staple a VOIDED check below)

ROUTING # : _____

ACCOUNT # : _____

I authorize the above named practice and Vanco Services, LLC to process debit entries to my account in accordance with the information above.

AUTHORIZED SIGNATURE: _____ DATE: _____

*****PLEASE attach voided check over credit card section if using checking account.*****

CREDIT CARD/DEBIT:

_____ VISA _____ M/C _____ AMEX _____ DISCOVER

CREDIT CARD NUMBER: _____

NAME AS IT APPEARS ON CARD: _____ EXPIRES: _____

BILLING ADDRESS (if different from above): _____

CITY: _____ STATE: _____ ZIP: _____

I authorize the above named practice and Vanco Services, LLC to charge my credit card in accordance with the information above.

AUTHORIZED SIGNATURE: _____ DATE: _____

GO GREEN! 

YES! I want to manage/view my account online. Please DO NOT send me paper statements.