Dr. McClurg's Smile Center
Authorization Agreement For Automatic Withdrawal Of Funds

Parent Last Name_____ **Parent First Name**_____ **Patient Name:**_____

Address_____

City_____ **State**_____ **Zip**_____

CHECKING/SAVINGS

Please debit payment from my: **Routing Number:** _____
___Savings Account (contact your financial institution for Routing #) Valid Routing # must start with 0, 1, 2, or 3

___Checking Account **Account Number;**_____

I authorize Dr. McClurg's Smile Center and Vanco Services, LLC to process debit entries to my account. I understand that this authority in effect until I provide reasonable notification to terminate the authorization.

Authorized Signature: _____ **Date:** _____

Date for monthly withdrawal: ___ 5th ____ 20th _____ Other

PLEASE STAPLE VOIDED CHECK HERE COVERING CREDIT CARD SECTION

CREDIT CARD

Please charge my payment to my (check one): ___ Visa ___ MasterCard ___ American Express ___ Discover Card

Credit Card Number: _____ **Expiration Date:** _____
CVC # (3 digit security number on back of card): _____

Name on Card: _____

Billing Address (if different from above):_____

I authorize Dr. McClurg's Smile Center and Linkpoint Services, LLC to charge my credit card with the information provided above. I understand that this authority in effect until I provide reasonable notification to terminate the authorization.

Authorized Signature: _____ **Date:** _____

Date for monthly withdrawal: ___ 5th ____ 20th _____ Other

PLEASE PROVIDE PROOF OF CREDIT CARD WHEN SUBMITTING PAPERWORK

FOR OFFICE USE ONLY:
MONTHLY PAYMENT

Date of first payment: ___/___/___ Date of last payment: ___/___/___

Amount of first payment: $____ Amount of monthly payment: $_____ Amount of last payment: $_____