Patient Name: ____Patient#________________

ACH AUTO DEBIT

AUTHORIZATION AGREEMENT FOR DIRECT PAYMENTS

COMPANY NAME: Robert Norris, DDS, PC Stone Oak Orthodontics

I (we) hereby authorize Robert Norris, DDS, PC, (Stone Oak Orthodontics), hereinafter called COMPANY, to initiate debit entries to my (our):

CHECKING ACCOUNT_____ SAVINGS ACCOUNT_____

After selecting one of the above accounts please indicate below the depository/financial institution (**BANK**) name. I (we) acknowledge that the origination of ACH transaction to my (our) account must comply with the provisions of the U.S. law.

NAME (S) ON ACCOUNT:____

FINANCIAL INSTITUTION NAME: _______________________________________

CITY: ______________________________ STATE:__________________________

SIGNATUE:_________________________________ DATE:___________________

NOTE: ALL WRITTEN DEBIT AUTHORIZATION MUST PROVIDE THAT THE RECEIVER MAY REVOKE THE AUTHORIZATION ONLY BY NOTIFYING THE ORIGINATOR IN THE MANNER SPECIFIED IN THIS AUTHORIZATION. ANY CHANGES BY RESPONSIBLE PARTY WILL REQUIRES A 14-DAY NOTICE ________.

START DATE: __________________ AMOUNT: _______________________

END DATE: ____________________ AMOUNT: _______________________

VOIDED CHECK REQUIRED