DENTAL Services

Providing all services for the Dental Professional

Bank Account Withdrawal Authorization Form

Name On The Account: _____

Type of Account (please circle one):

Business Checking Business Saving Personal Checking Personal Savings

Routing Number: _____ Account Number: _____
Billing Address: _____
City:_____ State:_____ Zip Code: _____
Billing Phone Number:_____

Please initial next to each statement, indicating your agreement and acceptance of each term.

_____ I authorize DENTAL SERVICES to withdraw funds from the account provided above as payment for invoices.
_____ I authorize DENTAL SERVICES to keep this account information on file for future use-with consent.
_____ I acknowledge that it is my responsibility to notify DENTAL SERVICES if there are any changes to this account, or if I do not want to use this account for payments.

AUTO-PAY ENROLLMENT OPTION

_____I would like to enroll in Auto-pay. This will authorize DENTAL SERVICES to withdraw funds from the account (provided above) for open invoices, without individual consent for each invoice.

_____ I am declining the Auto-Pay enrollment at this time.

Please provide an e-mail address to send receipts and invoices: _____

Signed:_____ Date: _____

Print Name: _____ Title:_____

Please return this form to LFDentalServicesNV@gmail.com
or send a picture via text to (702) 274-0088