# AUTOMATED CLEARING HOUSE (ACH) AUTHORIZATION

edmonds
DENTAL PROSTHETICS

→ EdmondsDentalProsthetics.com

2065 W. Woodland
Springfield, MO 65807

1.800.462.3569
FAX: 417.881.0484

This form is used for Automated Clearing House (ACH) payments. The information collected on this form will be used by Edmonds Dental Prosthetics to electronically transmit payment data to Edmonds' financial institution.

Laboratory fees will be charged at the end of each month. Invoices and end-of-month statements are accessible through the Edmonds Doctor Portal on our website.

## Please Complete This Form in Its Entirety and Return It to Edmonds Dental Prosthetics

Doctor: _____

Practice Name: _____

License Number: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Accounting Contact: _____

Accounting Phone: _____

Accounting Email: _____

Acct. Holder Name: _____

Bank Name: _____

Account Number: _____

Routing Number: _____

I, the undersigned, authorize Edmonds Dental Prosthetics to keep my bank account information on file, and pay my monthly laboratory fees from this account. I also authorize the financial institution named above to post these transactions to my account.

_____
Account Holder Signature

_____
Print Name Date

PLEASE PRINT A COPY FOR YOUR RECORDS