HEALTHY SMILES ADVANTAGE

AUTHORIZATION AGREEMENT
ACH PREAUTHORIZED PAYMENTS (DEBITS)

I hereby authorize *Thomas S. Browder, DDS* to initiate debit entries or such adjusting entries, either debit or credit which are necessary for corrections, to my checking or savings account indicated below and the financial institution named below to credit (or debit) the same to such account.

Financial Institution Name City State

Transit/Routing Number Account Number

I understand that this authorization will be in effect until I notify my financial institution in writing that I no longer desire this service, allowing it reasonable time to act on my notification. I also understand that if corrections in the debit amount are necessary, it may involve an adjustment (credit or debit) to my account.

I have the right to stop payment of a debit entry by notifying my financial institution before the account is charged. If an erroneous debit entry is charged against my account, I have the right to have the amount of the entry credited to my account by my financial institution. I agree to give my financial institution a written notice identifying the entry, stating that it is in error, and requesting credit back to my account. I will provide this written notice within 15 calendar days following the date on which I was sent a statement of my account or a written notice of such entry, or 45 days after posting, whichever occurs first.

Name (printed)

Signature Date