AUTHORIZATION AGREEMENT FOR DIRECT PAYMENTS (ACH DEBITS)

The Dental Suite
Michelle P. Kleinheider D.M.D
1167 Colonnade Ctr.
Des Peres, MO 63131

I (we) hereby authorize Michelle P. Kleinheider, D.M.D , LLC to initiate debit entries to my (our) account indicated below at the depository financial institution named below, hereinafter called DEPOSITORY. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law. A 60 day written notice is required for termination of the plan, after the 60 days your depository information will be cleared from our ACH Debits and will no longer be charged.

Depository (Bank) Name_____

City _____ State _____ Zip _____

Routing Number _____ Checking ❒

Account Number _____ Savings ❒

Monthly Debit Amount $_____

I understand that the amount debited will be renewed and subject to change on January of each subsequent year by the percentage change in the CPI as outlined in the terms of the Dental Plan contract.

This authorization is to remain in full force and effect until Michelle P. Kleinheider, D.M.D , LLC has received written notification from me (or either of us) of its termination in such time and in such manner as to afford Michelle P. Kleinheider, D.M.D, LLC and DEPOSITORY a reasonable opportunity to act on it.

Name_____ Signature_____ Date_____

Name _____ Signature _____ Date _____