ACH Authorization Form

I/We_____authorize **Revolutionary Health Services** (the "Medical Practice") to initiate entries to my checking/savings account or my credit card account held at the financial institution listed below; and, if necessary, initiate adjustments for any transaction credited/debited in error. This authority will remain in effect until the Medical Practice is notified by me/us, in writing, to make any changes, giving at least five (5) business days' notice prior to the next agreed-upon, scheduled payment date.

_____

Name of Financial Institution

_____

Address of Financial Institution

_____

Customer Service Number/Contact

Type of Account:

☐ Checking ☐ Savings

_____

Account Number

_____

Financial Institution Routing Number (Checking/Savings ONLY)

_____

Accountholder Names(s)

Start Date : ____/ ____/____ Amount: $ _____

Please include a voided check (checking account), deposit slip (savings account), or a clear copy of the front and back of your credit card.

Signed:_____Date (MM/DD/YY):____/____/ ____

Please note, in the event that any credit card transaction is declined or an ACH payment is returned for insufficient funds, the appropriate accountholder will be notified by the Medical Practice. All such instances must be resolved within ten (10) business days, including any fees incurred by the Medical Practice as a result. The Medical Practice reserves the right to represent any payment and may require an alternate method of payment for future charges.