



Authorization Agreement for Direct Payments from Checking/Savings

I/we hereby authorize LIFECHOICES MEDICAL CLINIC & RESOURCE CENTER™, hereinafter called COMPANY, to initiate debit entries from my (our) ____ Checking Account or ____ Savings Account (select one) indicated below at the depository financial institution named below, hereafter called DEPOSITORY, and to debit the same to such account. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law.

Name(s) on Account: _____
Home Address _____ City _____ State _____
Zip _____ Phone (____) _____ Email _____
Bank Branch _____ City _____ State _____ Zip _____
Routing Number _____ Account Number _____
Amount to be debited One Time Monthly Other (Please indicate) _____
If this gift is to be recurring, what date would you like it debited each month? _____
What is the start date ____/____/____ you would like to schedule?

This authorization is to remain in effect until COMPANY has received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DESPOSITORY a reasonable opportunity to act on it.

Printed name _____ Signature _____ Date _____

Authorization Agreement for Direct Payments from Credit/Debit Card

I/we hereby authorize LIFECHOICES MEDICAL CLINIC & RESOURCE CENTER™, hereinafter called COMPANY, to initiate debit entries from my (our) credit/debit card indicated below at the depository financial institution named below, hereafter called DEPOSITORY, and to debit the same to such account. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law.

Name(s) On Card _____
Billing Address of Card _____ City _____ State _____
Zip _____ Phone (____) _____ Email _____
16 Digit Account Number on Card _____ Expiration Date ____/____
3 Digit Security Code from back of the card _____
Amount to be debited One Time Monthly Other (Please indicate) _____
If this gift is to be recurring, what date would you like it debited each month? _____
What is the start date ____/____/____ you would like to schedule?

This authorization is to remain in effect until COMPANY has received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DESPOSITORY a reasonable opportunity to act on it.

Printed name _____ Signature _____ Date _____