HEALTHCARE
MANAGEMENT • SYSTEMS

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AUTHORIZATION AGREEMENT FOR ACH PAYMENTS/DEBITS

I(We) do hereby authorize Healthcare Management Systems, to initiate Recurring (debit) entries to (my/our) account indicated at the depository financial institution named below, hereafter named FINANCIAL INSTITUTION.

I further authorize Healthcare Management Systems to initiate an adjusting or correcting entry as necessary.

Finally, should any such debit(s) be returned as NSF or Uncollected Funds, I(we) authorize Healthcare Management Systems to collect such debit(s) electronically and to subsequently collect a Returned Item Fee of $25.00 (or the maximum allowed by state law, whichever is greater) per item, electronically from the same account identified below.

I am a duly authorized signer on the account identified below, and authorize all of the above as evidenced by my signature below.

Financial Institution Name: **:** _____

Checking: or Savings: Checking

Account Name: _____

Routing Number: **:** _____ **Account Number:** _____

RECURRING DEBITS

Payment Start Date: _____ **Amount:** Variable based on invoice, not to exceed: _____
Number of Payments: monthly until services terminated.

This authorization is to remain in full force and effect until Healthcare Management Systems has received written notification from me (or either of us) of its termination in such time and in such manner as to afford Healthcare Management Systems a reasonable opportunity to act.
Notice of revocation of authorization should be sent to the address listed below:

Accounts Receivable
Healthcare Management Systems
3010 Beard Road
Napa, CA 94558

Printed Name: _____

Signature: _____Date:_____