Author: Attorney Dan A. Riegleman

 N63 W23965 Main Street

 Sussex, Wisconsin 53089

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**Patient’s Authorization for Bank Payments (“EFT” Debits)**

Individual(s) Name:

Address:

City:

State: Zip Code:

Phone Number: ( )

Name of Financial Institution:

Routing #:

Patient Name(s):

Account #(s):

I (we) hereby authorize (name of office) to initiate debt entries to my (our) checking account indicated on the attached voided check at the depository financial institution named on such document, hereinafter called Depository, and to debit the same to such account. I (we) acknowledge that the originator of the (name of office) transactions to my (our) account must comply with the provisions of U.S. law.

This authorization is to remain in full force and effect until (name of office) has received written notification (signed by all names on the bank account) of its termination in such time and in such manner as to afford (name of office) a reasonable opportunity to act on it. (Initials)

**Attach Voided Check**

(all names on bank account need to sign below)

Print Name Signature Date

Print Name Signature Date

**NOTE: ALL WRITTEN DEBIT AUTHORIZATIONS MUST PROVIDE THAT THE RECEIVED MAY REVOKE THE AUTHORIZATION ONLY BY NOTIFYING THE ORIGINATOR IN THE MANNER SPECIFIED IN THE AUTHORIZATION.**

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