



517 US 31 NORTH
GREENWOOD, IN 46142-3932
888-323-0811

(Debtor/ Client Payment Authorization Form)

Name: _____

Address: _____

City _____ State _____ ZIP _____

PH _____ FAX _____ E-MAIL _____

Regular Monthly Payment Amount: \$ _____	Day of Pmt: _____
Regular Bi-weekly Payment Amount: \$ _____	Days of Pmt: _____
One-Time Pmt Amount: \$ _____	Day of Pmt: _____

Account Information:

Bank Name: _____

Routing Number: _____

Checking Account Number _____

I authorize the **Med-1 Solutions LLC** to electronically debit my checking/savings account for the amount and term indicated above. I understand that electronic debits will be returned if there are insufficient funds in the account at the time of the debit. I also understand that if my payment is returned to Med-1 Solutions, LLC as NSF or for any other reason by the bank that I authorize Med-1 Solutions, LLC to initiate an additional and separate \$25.00 fee for the returned check expenses. This authorization is to remain in full force and effect until Med-1 Solutions, LLC has received written notification from me of its termination in such manner as to afford Med-1 Solutions, LLC a reasonable opportunity to act on it (3 business days). Finally, I understand that the amount indicated includes a service charge of \$7.00 per transaction, which will not be applied to the balance due.

(Attach Voided Check)

Signature: _____

Date: _____