Northwest Cancer Specialists

ACH Pre-Authorization Form

I, we, authorize Northwest Cancer Specialists to keep my signature on file and to initiate debit entries to my (our):

□ Checking Account □ Savings Account (*select one)*

indicated below, at the depository financial institution named below, herein called DEPOSITORY, and to debit the following to such account:

- ❑ **Balance remaining after claim (s) is (are) resolved not to exceed $_____ for:**
  - ❑ This consultation only
  - ❑ All consultations this calendar year
  - ❑ All consultations from _____ to _____
    (date) (date)
- ❑ **Recurring charges of $_____ to be charged every _____**
  (frequency)

  From _____ to _____
  (date) (date)
- □ **Charges for the following family members:**

_____ _____
(authorized family member) (authorized family member)

_____ _____
(authorized family member) (authorized family member)

Depository
Name_____ Branch_____

City_____ State_____ Zip_____

Routing
Number_____ Account
Number_____

I (we) also acknowledge that our paper check may be turned into an electronic funds withdrawal from our account and understand we will not receive our check back from our financial institution

I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law.

Name(s)_____
(Please print)

Date: _____ **Signature**_____

This authorization is valid until I (we) provide you with written cancellation.