ACH CREDIT OR DEBIT AUTHORIZATION AGREEMENT

COMPANY NAME	COMPANY IDENTIFICATION NUMBER

☐ **PRE AUTHORIZED PAYMENTS**

I (We) hereby authorize N/A, hereinafter called COMPANY, to initiate debit entries to my (our) Checking account indicated below and the depository institution named below, hereinafter called DEPOSITORY, to debit the same to such account.

☐ **AUTOMATIC DEPOSITS**

I (We) hereby authorize Children's Physician Medical Group, Inc., hereinafter called COMPANY, to initiate credit entries and to initiate, if necessary, debit entries and adjustments for any credit entries in error to my (our) ☐ Checking ☐ Savings account (select one) indicated below and the depository institution named below, hereinafter called DEPOSITORY, to credit and/or debit the same to such account.

DEPOSITORY NAME	BRANCH	
CITY	STATE	ZIP CODE
TRANSIT/ABA NUMBER	ACCOUNT NUMBER	

This authority is to remain in full force and 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 DEPOSITORY a reasonable opportunity to act on it.

NAME(S) (Please Print)	IDENTIFICATION NUMBER	
DATE	SIGNATURE	SIGNATURE

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☐ I (We) do not wish to participate in automatic deposits of monthly capitations from Children's Physician Medical Group, Inc., at this time. I (We) understand these payments will continue to be made via live check.