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Logan, WV 25601

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RETINA CONSULTANTS, PLLC

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Practice Limited to
Diseases and Surgery of the Retina, Macula, and Vitreous
Diabetic Retinopathy
Macular Degeneration
Ultrasonography

AUTHORIZATION AGREEMENT
ACH PREAUTHORIZED PAYMENTS (DEBITS)

I hereby authorize Retina Consultants, PLLC to initiate debit entries from my checking or savings account indicated below and the financial institution named below to debit the same to such account.

____
FINANCIAL INSTITUTION NAME CITY STATE

____
TRANSIT/ROUTING NUMBER ACCOUNT NUMBER

ACCOUNT TYPE: CHECKING ________ SAVINGS __________ (Check one)

AMOUNT TO BE DEBITED MONTHLY $__________

Please indicate your preference:

Debit my account on the 3rd day of the month ☐

Debit my account on the 20th day of the month ☐

I understand that this authorization will be in effect until I notify Retina Consultants, PLLC_ and my financial institution in writing that I no longer desire this service, allowing it reasonable time to act on my notification.

I have the right to stop payment of a debit entry by notifying my financial institution before the account is charged. If an erroneous debit entry is charged against my account, I have the right to have the amount of the entry credited to my account by my financial institution. I agree to give my financial institution a written notice identifying the entry, stating that it is in error, and requesting credit back to my account. I will provide this written notice within 15 calendar days following the date on which I was sent a statement of my account or a written notice of such entry, or 45 days after posting, whichever occurs first.

____
NAME

____
ADDRESS APARTMENT #

____
SIGNATURE DATE

****** I am attaching a voided check to verify my bank information with the understanding that the check will be destroyed after the verification process is completed.**