

Jacksonville Heart Center, PA

1905 Corporate Square Blvd.

Jacksonville, FL 32216

Phone: 904-720-0799

Fax: 904-720-5225

Fax Form and Voided Check To: 904-720-5225

ATT: Patient Account Payment

AUTHORIZATION AGREEMENT FOR PRE-AUTHORIZED COLLECTIONS (ACH DEBITS) – Payment Plan

I authorize Jacksonville Heart Center, PA to initiate a debit entry to my (our) checking or savings account as listed below in the amount of \$ _____ on or after the _____ day of each month.

FINANCIAL INSTITUTION NAME: _____

*BANK TRANSIT / ABA NO.: _____

*Nine digit routing number that appears on the bottom of a check (Include a voided check with authorization)

BANK ACCOUNT NO. : _____

TYPE OF ACCOUNT: CHK SAV

PATIENT ACCOUNT#: _____ PATIENT REFERENCE#: _____

PRINTED NAME(S): _____

SIGNATURE: _____

This authority is to remain in full force and effect until Jacksonville Heart Center has received written notification from me (or either of us) of its termination in such time and in such manner as to afford the company a reasonable time to act on it.

DAY TIME PHONE NUMBER: _____ DATE: _____