



**CCD Payment Authorization Agreement**

Contact Information			
Company Name			
Address:	City:	State:	Zip:
Home Phone:	Work Phone:		
Payment Plan Schedule			
<input type="checkbox"/> One-time Payment      Payment Amount: \$ _____ Payment Date: _____ <input type="checkbox"/> Recurring Debit every: _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly			
Customer Bank Account Information			
Individual or Company Name as it appears on bank account:		Bank Name:	
Account Type: <input type="checkbox"/> Checking <input type="checkbox"/> Savings	Routing Number:		Account Number:

**Payment Authorization**

I authorize \_\_\_\_\_ to initiate ACH Debits and/or Credits to my bank account. I understand that this authorization will remain in effect until I cancel this authorization by contacting \_\_\_\_\_ of any changes in my account information or termination of this authorization at least \_\_\_\_\_ days prior to the next billing date. If the above noted periodic payment dates fall on a weekend or holiday, I understand that the payment may be executed on the next business day. I understand that because this is an electronic transaction, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates.

In the case of an ACH Transaction being returned for Non- Sufficient Funds (NSF) I understand that \_\_\_\_\_ may at its discretion attempt to process the charge again (up to 2 times) and agree to an additional \$\_\_\_\_\_ charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I agree not to dispute this billing with my bank so long as the transactions correspond to the terms indicated in this authorization form.

\_\_\_\_\_  
Customer Signature

\_\_\_\_\_  
Date

**A voided check from customer's bank account must accompany this authorization form. (if applicable)**