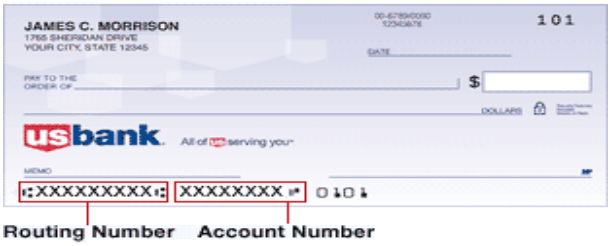
Fulton Psychological Group

Recurring ACH Payment Authorization

I authorize regularly scheduled charges to my checking/savings account. I will be charged at the time of service or at the end of our invoicing cycle (i.e. On the 15th or the end of the month). . If the service falls on a weekend or holiday, I understand that the payments may be executed on the next business day. The payment will be reflected on your invoice and the charge will appear on your bank statement as an "ACH Debit". I understand that no prior-notification will be provided unless the amount changes. In which case, you will receive notice from us at least 10 days prior to the payment being collected. I hereby authorize Fulton Psychological Group (FPG) to originate debit and/or credit entries via the Automated Clearing House to the account indicated at the Depository Financial Institution named below, to accept and to debit/credit the amount of such entries to the account. The amount charged is indicated on the consent form.

Account Name:	
Bank Name:	

Bank **Routing** Number:	
Bank **Account** Number:	



I understand this authorization will remain in effect until I cancel it in writing. I agree to notify FPG in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing dates In the case of an ACH transaction being rejected for Non-Sufficient Funds (NSF) I understand FPG may at its discretion attempt to process the charge again within 30 days, and agree to an additional $25 charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this bank account and will not dispute these scheduled transactions with my bank; so long as the transactions correspond to the terms indicated in this authorization form.

SIGNATURE:_____ DATE: _____

(Account Holder's Signature)

Patient's Name: _____ Dr.'s Name: _____