EAST BAY FAMILY THERAPY

PAYMENT AUTHORIZATION FORM

FOR OFFICE USE ONLY	CUSTOMER #	DATE

Effective date of authorization: _____/_____/_____

Type of authorization:
- ❑ New authorization
- ❑ Change banking information
- ❑ Change payment amount
- ❑ Discontinue electronic payment
- ❑ Change payment date

Last Name	First Name	
Address		
City	State	Zip
Email Address		

PER SESSION PAYMENT:

Date of first payment: ______/______/______ Amount of payment: $____________

CHECKING / SAVINGS

Please debit payment from my (check one):

- ❑ Savings Account (contact your financial institution for Routing #)
- ❑ Checking Account (staple a voided check below)

Routing Number: ______________________________
Valid Routing # must start with 0, 1, 2, or 3

Account Number: ______________________________

⑆123456789⑆ 123 123456⑈ 0001

Routing Number — Account Number — Check Number

I authorize the above organization to process debit entries to my account. I understand that this authority will remain in effect until I provide reasonable notification to terminate the authorization.

Authorized Signature:____ Date:________________

If using a checking account, please attach a voided check to the bottom of this page.