ACH PAYMENT AUTHORIZATION FORM

Please complete this form to authorize electronic ACH payments from your bank account.

Customer Information

Customer / Company Name:

Billing Address:

City, State, Zip:

Phone Number:

Email Address:

Payment Details

Payment Type: ☐ One-Time Payment ☐ Recurring Payment

Amount Authorized: $

Payment Date or Schedule:

Invoice Number(s) / Description:

Bank Account Information

Account Holder Name:

Bank Name:

Routing Number:

Account Number:

Account Type: ☐ Checking ☐ Savings

Do NOT email this completed form. It carries payment details. Return it by fax to 847.806.0464, or call +1 (630) 768-6784 to arrange a secure alternative.

Authorization

I authorize OptiTrimMD to electronically debit the bank account listed above for the payment amount indicated. I certify that I am an authorized signer on this bank account. I understand that this authorization will remain in effect until I cancel it in writing.

Authorized Signature:

Printed Name:

Date:

Please return the completed form along with a voided check to ensure accurate bank information.