



ACH Authorization Agreement Authorization Form

Today's date: _____

I: _____

I (We) do hereby authorize First Alternative Care here after named COMPANY, to initiate Recurring debit entries to (my/our) account indicated at the financial institution or bank named below, hereafter FINANCIAL INSTITUTION. I further authorize COMPANY to initiate an adjusting or correcting entry as necessary. Finally, should any such debit(s) be returned as non-sufficient funds or uncollected funds, I (We) authorize the COMPANY to collect such debit(s) electronically to subsequently collect a fee electronically from the same account identified below.

Name on Account : _____

Financial Institution / Bank Name *: _____

Type of Account: Checking Savings

Routing Number: _____

Account Number _____

Start Date of Payments _____

I Understand Payments are Continuous until Canceled: Payment are Continuous

Amount in USD \$: _____

Street: _____

City: _____ State: _____ Zip Code: _____

Email: _____

Date of Birth: _____

Telephone: _____

Cardholder or Company Representatives Signature: _____

User Name: _____

This is for the login in information for the platform. You may change it once you have access. Including the security questions.

Password: _____

Security Question First Pet: _____

This authorization is to remain in full force and effect until the COMPANY has received written notification from me of its termination in such time and in such manner to afford the COMPANY a reasonable opportunity to act. Notice of Revocation can be mailed to the address below or email to Info@FirstAlternativeTherapies.com.

This Authorization can be faxed to 772-872-6620 or Emailed to Info@FirstAlternativeTherapies.com

