RIGHT ACCORD
Private Duty-Home Health Care
1960 South Tamiami Trail Venice, FL 34293
941.366.0801| www.rightaccordhealth.com

Bank Transfer Authorization Form

I authorize _____ to electronically debit my bank account according
Business Name

to the terms outlined below. I acknowledge that electronic debits against my account must comply with United States law.

Terms of billing:

☐ One time on _____ for the amount of $_____.
mm/dd/yy

☐ Starting on _____ and on the _____ of each month through _____
mm/dd/yy Day of the Month mm/dd/yy

for the amount of $_____.

☐ Starting on _____ for the amount of $_____ and accordingly thereafter per
mm/dd/yy

the terms in invoice(s) _____.

Customer bank account information:

_____ _____
Routing Number Account Number

Account type: ☐ Checking ☐ Savings ☐ Consumer ☐ Business

This payment authorization is to remain in effect until I, _____, notify
Customer Name

_____ of its cancellation by giving written notice in enough time for the
Business Name

business and receiving financial institution to have a reasonable opportunity to act on it.

_____ _____ _____
Customer Signature Customer Printed Name Date