North Texas Eye Center

ACH Pre-Authorization Form

I, we, authorize North Texas Eye Center to keep my signature on file and to initiate debit entries to my (our):
Checking Account Savings Account (*select one)*

indicated below, at the depository financial institution named below, herein called DEPOSITORY, and to debit the following to such account:

- ❑ **Balance remaining after claim (s) is (are) resolved not to exceed $______________ for:**

  - ❑ This consultation only
  - ❑ All consultations this calendar year
  - ❑ All consultations from __________________________ to ______________________________________
    (date) (date)

- ❑ **Recurring charges of $_______________________ to be charged every _____________________________**
  (frequency)

  From ____ to ____
  (date) (date)

  Charges for the following family members:

  ____ ____
  (authorized family member) (authorized family member)

  ____ ____
  (authorized family member) (authorized family member)

Depository
Name____ Branch______________________________________

City____ State_____________ Zip________________________

Routing
Number____ Account
Number_____________________________________

I (we) also acknowledge that our paper check may be turned into an electronic funds withdrawal from our account and understand we will not receive our check back from our financial institution

I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of

U.S. law.

Name(s)____
(Please print)

Date: _______________________ **Signature**____

This authorization is valid until I (we) provide you with written cancellation.