ACH Debit | Authorization Form

Soul Care for Black Clinicians® Academy Payment Authorization

Name:

_____

Please Print: First Middle Last

Address:_____ Date of Birth: _____

City/State/Zip:_____ Last 4 digits of Social Security #: _____

Home Phone: (_____) _____ Driver's License #: _____

Work Phone: (_____) _____ Driver's License State: _____

Payment Plan Schedule

Recurring Debit every: _____ Day(s) Week(s) Month(s) OR: One-time Payment

Start Date: Month: _____ Day: _____ Year: _____ Payment Amount: $_____

(Start date must be at least 15 business days from submission of this form)

End Date: Month: _____ Day: _____ Year: _____ Transaction Fee: $_____

Number of Payments: _____ Total Payment: $_____ (Payment Amount + Transaction Fee)

Customer Bank Account Information

Bank: _____ Phone Number: (_____) _____

Routing Number: _____

Account Number: _____

A voided check must be attached to this form.

Payment Authorization

I authorize my bank to debit my account as identified above to the terms stated here. This authorization shall remain in effect until the Service Provider and bank receive written notification from me of intent to terminate at such time and in such manner as to afford the Service Provider and bank reasonable opportunity to act (Minimum 30 days).

I understand that if the total amount owed to the Service Provider is increased, I authorize this plan to continue as long as the payment amount remains unchanged until the amount owed to the Service Provider is paid off or unless the plan is terminated earlier by me as above. I understand any added amounts can be applied for with a new ACH Debit Authorization Form.

All other changes, such as payment amount, frequency, and bank account number change, will require a new ACH Debit Payment Authorization Form to be filled out and submitted to Merchant 15 days prior to any change being implemented. I understand that this payment plan may be canceled by the Service Provider or Merchant due to NSF (Non-sufficient Funds). I will be liable to pay an NSF fee of $25.00 (or the amount allowable by law), which may be automatically debited for each NSF.

I represent and warrant that I am authorized to execute this payment authorization for the purpose of implementing this payment plan. I indemnify and hold the Service Provider, the bank, and the Merchant harmless from damage, loss, or claim resulting from all authorized actions hereunder.

Customer Signature: _____ Date: _____

Second Authorized Signature of Bank Account if Required: _____ Date: _____