



DIRECT PAYMENT AUTHORIZATION FORM

I hereby authorize Samaritan Center, to initiate debit entries to my account indicated below and the financial institution named below, hereinafter called FINANCIAL INSTITUTION, to debit the same to such account. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. Law.

Primary Account (Net Payment Amount)

Financial Institution Name

Address

City

State

Zip

Routing Number

Account Number

Type of Acct: Checking Savings

Amount to debit monthly

Debit on: First of month Fifteenth of month

This authority is to remain in full force and effect until Samaritan Center as received written notification from me of its termination in such time and manner as afford Samaritan Center and FINANCIAL INSTITUTION a reasonable opportunity to act on it.

Print Name

Signature

Date

PLEASE ATTACH VOIDED CHECK TO THIS FORM

FOR OFFICE USE ONLY

Rec'd Date _____ By _____ List ID _____