ACH Authorization Form

DEBIT AUTHORIZATION: I (we) authorize *Right Dose Pharmacy* to initiate a DEBIT, account money is taken or withdrawn from my (our) checking account at the financial institution listed below.

Name of Payer (please print) _____

Address of Payer:_____ City, State, Zip_____

Contact Phone #'s:_____

Financial Institution:_____ Phone: _____

Address of Financial Institution:_____ City, State, Zip_____

Routing #_____ Checking Account #_____

Please attach voided check for account verification purposes.

Right Dose Pharmacy Account to be paid by monthly ACH debit:

Customer Name: _____ Account #_____

Customer Address: _____ City, State, Zip_____

Amount to be debited monthly: Variable_____ Date to be debited: On first business day of each month

Signature Date

***This ACH authorization will remain in effect until I (we) notify in writing to *Right Dose Pharmacy* to cancel the ACH authorization. Required payment needs to be available in the payment account on the agreed payment date. I (we) release *Right Dose Pharmacy* of all liabilities concerning this payment if funds are not available to make the payment and I (we) will be responsible for making my(our) own payment.