BANK ACCOUNT PAYMENT INFORMATION UPDATE AUTHORIZATION

Thank you for agreeing to update your bank account payment information. Upon completion and return of this authorization, your bank account payment information will be integrated into our secure, automated merchant service and banking system. **In accordance with federal law, we require your signature to authorize all changes and updates in bank account payment information in order to continue payment for services, and all changes and updates shall apply to all patient accounts for whom you have agreed to make payment for services rendered.**

At your earliest convenience, please take a moment to review the bank account payment information given to us, and **sign** and **return** this document to us.

Bank Account: Name on Account:_____

Type: (circle one) CHECKING SAVINGS

Banking Institution:_____

Routing Number:_____

Account Number:_____

Telephone Number Associated with Account:_____

This payment information applies to services rendered for the following patients:

Name:_____ DOB:_____

Name:_____ DOB:_____

Name:_____ DOB:_____

Name:_____ DOB:_____

I attest that the payment information above is accurate and complete and authorize Summit Medicine and Pediatrics PLC to continue to charge my bank account according to the terms and conditions previously acknowledged for services rendered.

Signature:_____ Date:_____

Name:_____

INSTRUCTIONS: Once you have completed and signed this form, please fax the form to us at 480-656-0098, or mail the form to us at: Summit Medicine and Pediatrics, 6828 E. Brown Rd., Ste. 102, Mesa, AZ, 85207

Internal use only:

[ ] Initial_____ [ ] Update_____

