

## **Bank Form Authorization**

Account Name:  Please state total monthly amount in US Dollars for the account (s) that are active and you utilize under Inmediata. Inmediata Health Group will perform an ACH debit transaction for the amount you specify in total on a monthly basis and/or when invoice payment is due.	
Accountholder Name:	
Bank Account Information:	Credit Card Information:
Bank Account #	Credit Card #
(ABA):	Exp Date:/
Account type: Check  Savings	CVV :
Comments:	
Account payable information:	
Contact billing name:	_
Billing Address:	<u>.</u>
City:State: Zipcode:	
Phone: Email:	
agree to pay and specifically authorize Inmediata Heprovided. I further agree that in the event my bank Inmediata Health Group with a new valid bank accopayment of any outstanding balances owed to Inmedia charge is returned by insufficient funds, I authorize to necessary.  I understand that ther willalsobe a charge of \$25.00 for	tand and agree to the terms set forth in this agreement, ealth Group. To debit my bank account for the services account or credit card becomes invalid, I will provide out or credit card upon request, to be charged for the ta Health Group. For bank accoun debits: In the event a process an automatic new debit as many times as deemed every charge returned by the bankand a reconnection fee of
\$50.00.A \$10.00 Monthly processing fee will be applied  I understand and agree to the aforementioned terms and co	
Provider Printed Name:	
Provider Signature:	
Rev 7/2025 Accounting	