Recurring Payment ACH Payment Authorization Form

Please complete all fields. You may cancel this authorization anytime by contacting
Nina Anderson, MD, Robert S. Burnstein, MD, Robert Piccinini, DO, or Eleanor Kulis, MD.
43157 Schoenherr Sterling Heights, MI 48313
PH: (586) 997-9619 or FAX: (586) 997-9635

Billing Information	
Name, Company, Group, or Organization:	
Address:	
City, State, ZIP Code:	
Phone Number:	Email Address:

Bank Account Information	
Bank Account Name:	
Account Holder Name (as shown on check):	
Routing Number:	
Account Number:	Account State:
Account Holder ZIP Code:	

By signing this form, I authorize **Nina Anderson, MD,** ***Robert S. Burnstein, MD, Robert Piccinini, DO, or Eleanor Kulis, MD,*** to charge my account for recurring payments starting on or after _____. This authorization will remain in effect until I notify **Nina Anderson, MD,** ***Robert S. Burnstein, MD, Robert Piccinini, DO, or Eleanor Kulis, MD,*** before the next billing date.

I confirm that I am an authorized user of this credit card. I understand that my information will be securely stored for future transactions on my account.

CUSTOMER SIGNATURE _____DATE _____

PRINT NAME _____