The Morrison Hospital Association

AUTHORIZATION AGREEMENT FOR DIRECT PAYMENTS

***Resident Name*:** _____

I (we) hereby authorize The Morrison Hospital Association to initiate debit entries to the Checking / or Savings account indicated below for monthly Room & Board/Patient Liability and/or Medical supplies . I (we) acknowledge that the origination of ACH transactions to our account must comply with the provisions of U.S. law and NACHA rules.

Account Number: _____

Routing Number *(9 Digits)*: _____

_____ **Checking** _____ **Savings**

This authorization is to remain in full force and effect until The Morrison has received written notification from me of its termination in such time and in such manner as to afford The Morrison a reasonable opportunity to act on it.

Signature: _____ **Date:** ____/____/____

Please return to the Business Office.
Payments will be withdrawn from account between the 4th and 12th of the month.