MedStar

EMERGENCY MEDICAL SERVICES
551 E. Berry
Fort Worth, TX 76110
817-923-3700

AUTHORIZATION AGREEMENT FOR PREAUTHORIZED PAYMENTS

Patient Name_____ Run Number_____

I (we) hereby authorize Area Metropolitan Ambulance Authority dba MedStar EMS, hereinafter called COMPANY, to initiate debit entries to my (our) checking account indicated below at the depository named below, hereinafter called DEPOSITORY, to debit the same to such account.

DEPOSITORY
NAME_____ BRANCH_____

CITY_____ STATE_____ ZIP_____

ROUTING NUMBER_____ ACCOUNT NO._____

CREDIT CARD NUMBER_____ EXP DATE:_____

THREE DIGIT SECURITY CODE _ _ _

AMOUNT AUTHORIZED $_____ PER MONTH

DAY OF THE MONTH TO BE DRAFTED _____

This authorization is to remain in full force and effect until COMPANY has received written notification from one (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

NAME(S) _____
(PLEASE PRINT)

SIGNED X_____ DATE_____

SIGNED X _____ DATE _____

NOTE: ALL WRITTEN DEBIT AUTHORIZATIONS MUST PROVIDE THAT THE RECEIVER MAY REVOKE THE AUTHORIZATION ONLY BY NOTIFYING THE ORIGINATOR IN THE MANNER SPECIFIED IN THE AUTHORIZATION.