Physician Select Management
Authorization Agreement for Direct Debits (ACH Debits)

Company Name _____ **Company ID (Tax ID or SSN)** _____

I (We) hereby authorize Physician Select Management, herein after called "PSM", to initiate Debit entry(ies) and / or correction monthly entry(ies) in the amount of _____ to my(our)

☐ **CHECKING ACCOUNT**

or

☐ **SAVINGS ACCOUNT**

(select and check only one above) indicated at the depository named below, herein after called "DEPOSITORY," to credit the same to such account.

Depository Name _____ **Branch** _____

City _____ **State** _____

Bank Transit / ABA Number _____ **Account Number** _____

This authorization is to remain in full force until PSM has received written notification from the Company's authorized signatory of its termination in such manner as to afford PSM and DEPOSITORY reasonable opportunity to act upon it. Company shall provide written notification of changes in account information ten business days prior to any action. Any transaction returned for insufficient funds will incur an insufficient funds fee of US $35.00 and will be due immediately.

Name of Authorized Signer _____ **Title** _____

Signature _____ **Date** _____

Fax or send the authorization to:

accountsreceivable@psmnv.com
318 N. Carson St., Ste 214 • Carson City, NV 89701 •
Phone: (775) 885-2211 • **Fax**: (775) 885-0773