For Automatic Bank Draft, please print this form and mail to:
Primary Care and Hope Clinic
Attn: Bette McFarland
1453 A Hope Way
Murfreesboro, TN 37129

Primary Care & Hope Clinic
AUTHORIZATION AGREEMENT FOR AUTOMATIC BANK DRAFT

I hereby authorize Primary Care & Hope Clinic ______________________
hereinafter called ORGANIZATION, to initiate debit or credit entries to my Checking Account/Savings Account **(circle one)** indicated below at the depository financial institution named below, hereinafter called DEPOSITORY, and to debit/credit the same to such account. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U. S. law.

Financial Institution Name: ______________________________

Routing Number: ____________________ Account Number: ____________________

This authorization is to remain in full force and effect until ORGANIZATION has received written notification from me of its termination in such time and in such manner as to afford ORGANIZATION and DEPOSITORY a reasonable opportunity to act on it. Please submit written notification to Shane Smith, CFO Primary Care & Hope Clinic 1453A Hope Way, Murfreesboro, TN 37129 or e-mail at shane.smith@hopeclnc.org.

Name: ______________________________

Address ______________________________ Phone ____________________

Monthly Amount $ ______________________________ (circle one) 1st or 15th of month

Signature: ______________________________ Date: ____________________

Note: Please provide a voided check with this authorization form.