RECURRING ELECTRONIC FUNDS TRANSFER

EFT Authorization Form

Organization Name: _____

FOR 7 MEDICAL USE ONLY: **CUSTOMER #** _____ **DATE** _____

Effective date of recurring EFT payment authorization (MM/DD/YY): _____

Type of Authorization: ☐ New Authorization ☐ Change Banking Information ☐ Change Payment Amount ☐ Change Payment Date ☐ Discontinue Electronic Payment

Last Name:	First Name:	
Address:		
City:	State:	Zip:
Phone:	Email:	

EFT Payment Date(s): The first payment shall commence on the invoice due date in the first month of service following the service delivery date (or go-live date), according to the terms in the Master Service Agreement. Thereafter, monthly recurring payments will occur on the invoice due date and shall continue until the end of the contract term or until the contract is terminated. For contracts that auto-renew, monthly payments shall continue until the end of the contract term or until the contract is terminated.

Electronic Funds Transfer (EFT) Payment

Amount of Recurring Payment:

$ _____

CHECKING / SAVINGS (ACH)

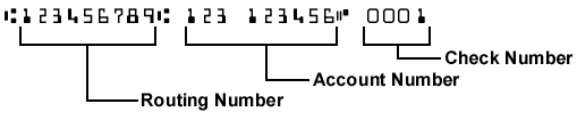
Please debit payment from my (check one):

☐ Savings Account (provide bank routing number)
☐ Checking Account

If you are using a checking account, please attach a voided check with this authorization form.

Bank Routing #: _____
(Valid routing number must start with 0, 1, 2 or 3)

Account #: _____



I authorize 7 Medical Systems, LLC to process automated clearing house (ACH) debit entries to my account. This authority will remain in effect until I provide reasonable notification to terminate the authorization.

Authorized Signature: _____ Date: _____

CREDIT / DEBIT CARD

Card Type: ☐Visa ☐ MasterCard ☐ AMEX ☐ Discover

Card Number:	Expiration Date:
Name on Card:	3 or 4 Digit Security #:
Billing Address (if different than above):	

I authorize 7 Medical Systems, LLC to process credit/debit card transactions in accordance with the information above. This authority will remain in effect until I provide reasonable notification to terminate the authorization.

Authorized Signature: _____ Date: _____

Submit this form to fax: 612-230-7702 or email: billing@7medical.com.

7 Medical Billing | 100 S. 5th Street, Suite 2200, Minneapolis, MN 55402 | 612-230-7731 | billing@7medical.com