

Central Florida Pediatrics
Authorization for ACH Transactions

Name: _____

SS#: _____

I hereby authorize Central Florida Pediatrics to initiate credit entries and to initiate, if necessary, debit entries and adjustments for any credit entries in error to my account, which is indicated below.

Account information

Name on account: _____

Type of account: Checking Savings Other: _____

Bank Name: _____

Routing #: _____

Account #: _____

Please attach a voided check (or check copy).

Employee Signature

Date