



5100 Gateway Centre Drive  
Flint, MI 48507

Phone: 810-733-6480 Fax: 810-733-8740

**Fax Form and Voided Check To: 810-733-8740**

**ATT: Patient Account Payment**

**AUTHORIZATION AGREEMENT FOR PRE-AUTHORIZED  
COLLECTIONS (ACH DEBITS) – Payment Plan**

I authorize Cardiology Institute of Michigan PLLC to initiate a debit entry to my (our) checking or savings account as listed below in the amount of \$ \_\_\_\_\_ on or after the \_\_\_\_\_ day of each month.

FINANCIAL INSTITUTION NAME:

\_\_\_\_\_

\*BANK TRANSIT / ABA NO.:

\_\_\_\_\_

\*Nine digit routing number that appears on the bottom of a check (Include a voided check with authorization)

BANK ACCOUNT NO. :

\_\_\_\_\_

TYPE OF ACCOUNT:    CHK    SAV

PATIENT ACCOUNT#: \_\_\_\_\_ PATIENT REFERENCE#:

\_\_\_\_\_

PRINTED NAME(S):

\_\_\_\_\_

SIGNATURE:

\_\_\_\_\_

This authority is to remain in full force and effect until Cardiology Institute of Michigan has received written notification from me (or either of us) of its termination in such time and in such manner as to afford the company a reasonable time to act on it.

DAY TIME PHONE NUMBER: \_\_\_\_\_

DATE: \_\_\_\_\_