Bank Transfer Authorization Form

I authorize JL Medical Billing Solutions, LLC to electronically debit my bank account according to the terms outlined below. I acknowledge that electronic debits against my account must comply with United States law.

Terms of billing:

☐ Starting on _____ for the amount due on the corresponding invoice (s).
mm/dd/yy

Customer bank account information:

_____ _____
Routing number Account number

Account type: ☐ Checking ☐ Savings ☐ Consumer ☐ Business

This payment authorization is to remain in effect until I, _____, notify
Customer name

JL Medical Billing Solutions, LLC of its cancellation by giving written notice in enough time for the business and receiving financial institution to have a reasonable opportunity to act on it.

_____ _____ _____
Customer signature Customer printed name Date