WASHINGTON PARK DIRECT CARE

208 Centralia College Blvd.
Centralia, WA 98531
360-736-0771
www.washingtonpark.md

ELECTRONIC FUNDS TRANSFER AGREEMENT (EFT)
Direct Payment Authorization Form

_____("I / we") hereby authorize Quick Clinic, dba Washington Park Direct Care ("the company") to initiate withdrawals from our/my account at the financial institution named in this application for payment of our monthly accounts payable to the company. Funds will be withdrawn once a month, on the date specified below. This contract may be terminated at any time, with written or verbal consent from the member.

Name of Financial Institution	Checking or Savings	Routing Number	Account Number	Fixed Amount

I / we have read and understand the terms of this agreement. I / we agree to be bound by the terms and will comply with all additional Rules and Regulations as they now exist, or any changes that may occur.

_____

Account Holder Signature Date

_____

Account Holder Signature Date

For the Company to verify bank account and routing numbers, account holders should attach a **VOIDED CHECK** for the account that is to be debited. The Company and account holder should retain completed copies of this form for their records.

THIS FORM IS FOR THE COMPANY / ACCOUNT HOLDERS USE ONLY.

It is not required to forward copies to Umpqua Bank.

CLINIC USE ONLY

Enrollment Fee Of:	Received On :	Received By:	EFT will begin on:
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