AUTHORIZATION AGREEMENT
DIRECT PAYMENTS (ACH DEBITS)

I (we) hereby authorize **HelpCare Clinic** (company name), hereinafter called COMPANY, to initiate debit entries and to initiate, if necessary, credit entries and adjustments for any debit entries in error to my (our) account indicated below and the financial institution named below, hereinafter called FINANCIAL INSTITUTION, to debit, if necessary, credit, the same to such account.

_____ _____
(Financial Institution Name) (Branch)

_____
(Address) (City/State) (Zip)

_____ _____
(Routing Number) (Account Number)

Type of Acct: ____Checking ____ Savings

Date of Withdrawal: ____1st of each month

____15th of each month

This authority is to remain in full force and effect until COMPANY has received written notification from me thirty days prior to its termination in such time and manner as to afford COMPANY and FINANCIAL INSTITUTION a reasonable opportunity to act on it.

_____ _____
(Print Individual Name) (Signature)

_____
(Date)

PLEASE ATTACH COPY OF VOIDED CHECK TO THIS FORM