



9279 N Port Washington Rd Bayside WI 53217

DIRECT PAYMENT AUTHORIZATION FORM

AUTHORIZATION FOR DIRECT PAYMENT

I authorize Elizabeth Residence to initiate electronic debit entries to my *checking* *savings* (circle one) account for the payment of the monthly service fee provided by the Elizabeth Residence Assisted Living facility.

I understand I will receive a notice only if the amount is more than \$ _____ or within the range of \$ _____ to \$ _____.

I acknowledge that the origination of ACH (Automated Clearing House) transactions to my account must comply with the provisions of United States law.

I understand that if the funds are unavailable I will communicate with the Central Billing Office (414-434-5203) in an effort to avoid any insufficient funds bank charges that will be my responsibility.

Date: _____

Financial Institution Name: _____

Account Number at Financial Institution: _____

Financial Institution Routing/Transit Number: _____

Please staple voided check to this notice.

Signature: _____