



ACH AUTHORIZATION FORM

CUSTOMER INFORMATION

Customer Full Legal Name:

Customer Address:

Telephone:

Fax:

Contact Name:

Email for Receipt:

PAYMENT INFORMATION

Name of Bank/Financial Institution:

Name of Account Holder:

Type of Account:

Nine-Digit Routing Transit Number:

Account Number

Recurring on the 1st of each month

Signature:	Title:
Print Name:	Date of Authorization:

As the authorized account holder, by signing above, I understand and agree to pay, and specifically authorize Iron ReHealth Bank to charge my bank account for the services provided. I further agree that in the event my bank account declines or becomes invalid, I will provide Iron ReHealth with a new, valid payment information upon request. Please return the completed form, via our secure [drop box at: https://members.geniusavenue.com/dropbox/](https://members.geniusavenue.com/dropbox/).