ACH Debit Authorization Agreement

AUTHORIZATION AGREEMENT FOR DIRECT PAYMENTS (ACH DEBITS)

Company Name **Medical Imaging Partnership, Inc.** (herein referred to as "Company")

Address **PO Box 106, Department C, Pewaukee, WI 53072-0106**

Company ID Number **26-4106879**

I (we) hereby authorize Company to initiate debit entries to my (our) Checking Account indicated below at the depository financial institution named below, hereinafter called DEPOSITORY, and to debit the same to such account. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law.

Depository Name (Name of your bank)	
Branch Name (If Applicable)	
City, State, Zip	
Routing Number	Please attach a voided check that we may use to
Account Number	verify this information. Thank you.

Amount to be withdrawn	$	**Monthly withdrawal on or about**	☐ **1st of month** ☐ **15th of month**
Specified purpose or general			

This authority is to remain in full force and effect until COMPANY and DEPOSITORY has received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it. I have (or either of us has) the right to stop payment of a debit entry by notification to DEPOSITORY at such time as to afford DEPOSITORY a reasonable opportunity to act on it prior to charging account. After account has been charged, I have the right to have the amount of an erroneous debit immediately credited to my account by DEPOSITORY, provided I (we) send written notice of such debit entry in error to DEPOSITORY within 15 days following issuance of the account statement or 45 days after posting, whichever occurs first.

Depositor Name	**Depositor Name**
Signature & Date	**Signature & Date**

Save money for MIP: Provide us with your email address and we will send your confirmation by email, saving MIP $2 per transaction

EMAIL: ____

Return this form to us at the address above or by email to donorservices@medicalimagingpartnership.org.