CO-PAY ACH WITHDRAWAL AUTHORIZATION FORM

I authorize Partners in Learning, Inc. (PIL) to initiate electronic debit entries to the account below for payment of patient responsibility amounts for (child's name) _____ for services rendered by Partners in Learning, Inc.

Please initial each statement below:

____ I authorize PIL to withdraw co-pay amounts weekly from my account below for service periods and withdrawal dates as per the attached CoPay ACH Withdrawal Schedule.

_____ I have reviewed the attached co-pay withdrawal schedule and agree to the corresponding deductions

_____ As per the terms of my medical insurance policy, a copay is applied and due on any/all days when services are provided for ABA medical codes covered under my policy, including for both direct and indirect services. The amount of the ACH withdrawal will vary weekly depending on the days of service provided, and will be between 1 and up to 7 times the amount of your daily copay.

_____ I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law.

_____ I understand this authorization will remain in effect until I have cancelled it in writing. PIL requires at least 5 business days notice in order to cancel this authorization.

_____ I agree to notify PIL immediately regarding any change to my bank account information.

_____ I understand that if funds are not available at the scheduled time of withdraw, a $10 late fee may apply as well as a $20 non-sufficient funds fee-per occurrence. These amounts, as well as the original ACH payment declined, will be charged to my account and added to my next regularly-scheduled payment.

DATE: _____

FINANCIAL INSTITUTION NAME (PLEASE PRINT): _____

FINANCIAL INSTITUTION ROUTING NUMBER: _____

ACCOUNT NUMBER AT FINANCIAL INSTITUTION: _____

FINANCIAL INSTITUTION CITY AND STATE: _____

TYPE OF ACCOUNT: CHECKING* / SAVINGS

NAME ON ACCOUNT: _____

SIGNATURE: _____

***for checking accounts, please attach a voided check**

**please note: upon initial setup of your account, we may make a small (few cents) deposit and/or complete a prenote authorization on your account to verify the accuracy of the bank account information before your first payment

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For Office Use Only: Policy Effective Date: _____

Daily CoPay Amount: _____ Maximum Weekly CoPay Amount: _____ ACH Start Date: _____
