Office Use Only SR -_____ INV- ____ RP-___	PR	DP	AMT$
Efiled______ Refund______ SS M S H	M B CPA QB PS	BK	#

www.ACT-CPA.com ~ 508-230-8756 ~ 50 Oliver Street, Suite 215 N. Easton, MA 02356

E-PAY FORM

I give permission to process an electronic check using the following information below. I take full responsibility for any bounced fees incurred if a payment is processed per the information below. Note: you can change a payment from processing, but we must have a written authorization 2 business days prior to the processing date and our office must have acknowledged the request. See the collection policy on the website.

First Name ________________________ Last Name ________________________________

Business Name (if applicable)________________________________

Phone Number________________________________

Email address (please print clearly) ________________________________

Would you like a copy of our email newsletter (circle)? YES NO

Bank Name____________________________________

Routing Number (9 digits) Account Number

			-				-			

I authorize one of the following payments for your services:

___ Please debit my account on ____/____/____ for $______________.

___ Please debit my account on the __________ of every month for $___________ to pay my fees as invoiced starting on ____________ until I give written permission to stop.

X_____________________________________ ________________

Signature **Date**