Office Use Only SR - _____ INV- _____ RP-	PR	DP	AMT$
Efiled_____ Refund_____ SS M S H	M B PS QB	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_____

Phone Number_____

Email address (please print clearly) _____

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

Business Checking Only: Business Name: _____

Bank Name_____

Routing Number (9 digits) /__/__/__/ __/__/__/ __/__/__/

Account Number /__/__/__/ __/__/__/ __/__/__/ __/__/__/ __/__/__/ __/__/__/

I authorize one of the following payments for your tax/accounting fee:

TAX ONLY CLIENTS:

___ Please debit my account on ___/___/___ for $_____.

___ Please pay my tax fee of $_____ plus $10.00 fee for a total of $_____ from my account when my refund is anticipated. Your tax fee will be debited on or before one month from the date your return is e-filed.

FINANCIAL PLANNING OR INVOICED CLIENTS

___ Please debit my account on the _____ of every month for $_____ to pay my accounting/tax fees as invoiced from starting on _____ until _____.

X_____ _____

Signature **Date**