

Office Use Only INV- _____ RP- _____	PR	DP	AMT\$
Efiled _____ Refund _____ SS _____ M S H	M B CPA QBO MEL	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 (if applicable, include zeroes in front of account #)

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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