

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