Jade | HEALTH CARE MEDICAL GROUP
翡翠東華醫師協會

DIRECT DEPOSIT/ACH AUTHORIZATION FORM

Complete the required information below to enroll, change, or cancel your current direct deposit at Jade Health Care Medical Group, Inc.

The following documents must be attached to this form:

- Voided Check (Checking Accounts Only)
- Completed and signed W-9 Form. Provider's business name must be identical to the bank account name and EIN/TIN.

I. Provider Information - (Please print legibly)

Provider Name

Employer/Tax Identification Number (EIN or TIN)

Business Name or DBA

Address

City

State

Zip Code

Phone Number

II. Direct Deposit Information

Circle one:

New Change Cancel

Account Information:

Account Holder Name

Checking Account #

Bank/Financial Institution Name

Bank Routing #

Bank Address

City

State

Zip Code

III. Authorization

1. By signing this agreement, I authorize Jade Health Care Medical Group, Inc. to automatically deposit my claim payment into my account(s) each payday. The Medical Group reserves the right to recall or adjust any deposits improperly created and deposited to my account. I understand my direct deposit service may be suspended or rescinded by the Medical Group at any time.
2. It is my responsibility to notify the Medical Group of any account closures or changes. If the direct deposit is not stopped before closing an account, I agree to wait until the funds are returned to the Medical Group to receive my funds. This could take several weeks and will delay my payment.
3. I understand I may revoke my direct deposit authorization at any time by providing written notification to the Medical Group.
4. It is my responsibility to ensure that my claim payment is properly credited to my account before issuing any debits against my account. I will hold the Medical Group harmless for any liability to pay charges for insufficient fund transactions that result from failure within the Automated Clearing House Network to correctly and timely deposit monies into my account.
5. I agree to hold harmless and indemnify Jade Health Care Medical Group, Inc and their employees, authorized personnel, from any claim or demand of whatever nature, including those based upon negligence, brought by any person, including any financial institution for failure or delay in making deposits and/or corrections to deposits as herein authorized. This authorization replaces any previously made by me and remains in effect until I cancel or submit a new authorization.

Signature: _____ Date: _____

Input by: _____ Date _____