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· (877) 425-6337 Phone
· (877) 509-6337 Fax
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ACH Authorization Form

Please print and complete all the information below.

Patient Name: ____

Billing Address: ____

City, State, Zip: ____

Email (optional): ____

Name of Bank: ____

9-Digit Routing #: ____

Account #: ____

Type of Account: Checking Savings

I_________________________________, authorize Ready Meds Pharmacy to debit my bank account, outlined above, for any balance owed on the monthly statement for the client above. I understand that I will continue to receive monthly statements for my information and review. I acknowledge that Ready Meds Pharmacy will be storing my account on a secure server for billing purposes only.

I understand that upon receiving notification of the client leaving the facility or passing away, Ready Meds Pharmacy will debit any remaining balance on the client's file to close out the account.

I agree to pay the Pharmacy a fee of $40.00 per RCW 62a.3-515 (b)(1) if for any reason your payment is not honored by your financial institution.

Account Holder Printed Name: ____

Account Holder Signature: ______________________________ **Date:** ____________

***Attach a voided check for which bank account to withdraw funds (if necessary)**