AUTHORIZATION AGREEMENT FOR PRE-AUTHORIZED (ACH) PAYMENTS

NEUROLOGICAL AND SPINAL SURGERY, LLC

I (we) authorize Neurological and Spinal Surgery, LLC to initiate debit entries to my (our) ☐checking/ ☐savings account (select one) indicated below and the depository financial institution named below to debit the same to such account. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law.

Depository Name: _____ Start Date: _____

Transit/ABA No.: _____ Account Number: _____

Payment Frequency: _____ Payment Amount: _____
(Subject to change upon notification by company or association).

Disclosures

This authority is to remain in full force and effect until Neurological and Spinal Surgery, LLC has received written notification from me (or either of us) of its termination in such time and in such manner as to afford Neurological and Spinal Surgery, LLC and Depository a reasonable opportunity to act on it. In no event shall it be effective with respect to entries processed by the Company prior to receipt of notice of termination.

I (we) further authorize the Neurological and Spinal Surgery, LLC to initiate such credit entries to said account as may be necessary to correct any erroneous debit entries previously initiated thereto. I (we) authorize the Depository to accept and to credit or debit the amount of such entries to my (our) account.

I (we) have the right to stop payment of any entry by notification to Neurological and Spinal Surgery, LLC 3 business days prior to the posting of item to the account.

The undersigned hereby agrees that all entries initiated hereunder are to be governed in all respects by the Rules of NACHA as now or hereafter in effect and agrees to be bound thereby:

Customer Name(s): _____Customer I.D. _____

Signed: _____ Signed: _____

Date: _____

Please attach voided check.