



# Amberwoods

OF FARMINGTON

NURSING AND REHABILITATION

## Authorization Agreement for Direct Payment (ACH/CC Debits)

I (we) hereby authorize Amberwoods of Farmington, to initiate debit entries, for services provided for \_\_\_\_\_ to my (our)

Checking Account /  Savings Account

Depository financial institution named below. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. Law.

ACH

Name \_\_\_\_\_ Branch \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Route \_\_\_\_\_ Account \_\_\_\_\_

Number \_\_\_\_\_ Number \_\_\_\_\_

(First 9 digits on bottom left of check)

(Remaining digits not including  
Check number)

In the amount of \$ \_\_\_\_\_ on the \_\_\_\_ day of \_\_\_\_\_.

Please note this will be a recurring monthly transaction unless otherwise notified in writing.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**This authority is to remain in full force and effect until COMPANY has received written notification from me(or either of us) of its termination in such time, but no less than 3 business days before any payments are due to be made, and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it**

860.677.1671

416 Colt Highway  
Farmington, CT 06032

[amberwoodsof.com](http://amberwoodsof.com)