ONE-TIME ELECTRONIC FUNDS TRANSFER

EFT Authorization Form

Organization Name: _____

FOR 7 MEDICAL USE ONLY: **CUSTOMER #** _____ **DATE** _____

Effective date of one-time EFT payment authorization (MM/DD/YY): _____

Last Name:	First Name:	
Address:		
City:	State:	Zip:
Phone:	Email:	

Payment Date: _____ **Amount of One-time Payment:** $ _____

CHECKING / SAVINGS (ACH)

Please debit payment from my (check one):

☐ Savings Account (provide bank routing number)

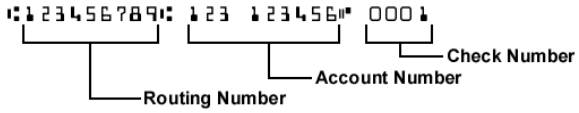
☐ Checking Account

If you are using a checking account, please attach a voided check with this authorization form.

Bank Routing #: _____

(Valid routing number must start with 0, 1, 2 or 3)

Account #: _____



I authorize 7 Medical Systems, LLC to process a one-time automated clearing house (ACH) debit entry to my account according to the information above.

Authorized Signature: _____ Date: _____

CREDIT / DEBIT CARD

Card Type: ☐Visa ☐ MasterCard ☐ AMEX ☐ Discover

Card Number:	Expiration Date:
Name on Card:	3 or 4 Digit Security #:

Billing Address (if different than above):

I authorize 7 Medical Systems, LLC to process a credit/debit card transaction in accordance with the information above. In addition to the one-time payment amount above, I understand that 7 Medical will charge my credit/debit card a processing fee equal to 3.5% of the one-time payment amount.

Authorized Signature: _____ Date: _____

Submit this form to fax: 612-230-7702 or email: billing@7medical.com.

7 Medical Billing | 101 S. 5th Street, Suite 2200, Minneapolis, MN 55402 | 612-230-7731 | billing@7medical.com