Authorization Agreement for Electronic Fund Transfers (ACH Debits and Credits)

1 on 1 Comprehensive Healthcare Solution LLC
14967 95th Place North, Maple Grove, MN 55369
Email: admin@1on1comprehensivehealthcare.com | Fax: (763) 402-7629

Resident & Responsible Party Information

Resident Name: _____
Responsible Party Name: _____

ACH Setup Request

■ Establish a new ACH account for automatic payments
■ Update existing ACH account or withdrawal date
Account Type: ■ Checking ■ Savings ■ Money Market
Start withdrawals on: ■ 1st ■ 5th Month to begin: _____
*Note: If no date is selected, withdrawals will default to the 5th of each month.

I hereby authorize 1 on 1 Comprehensive Healthcare Solution LLC to initiate ACH debit (withdrawal) entries from the account listed below to pay all monthly charges, including rent, services, and applicable fees. I also authorize the company to issue ACH credits in the event of an overpayment, error, or refund due.

I acknowledge:
- Setup may take up to six (6) weeks.
- Any changes or closure of the account must be reported in writing.
- A new form is required for any account update.
- This authorization remains valid until canceled in writing with reasonable notice.
- Two (2) consecutive insufficient fund notices may result in termination of this agreement.
- A valid email is required for any ACH-based refund processing.

Signature: _____ Date: _____

Daytime Phone: _____ Evening Phone: _____
Email Address: _____

Attach a Voided Check or Official Bank Letter
- Deposit slips are not accepted
- Handwritten banking info is invalid
- Auto-withdrawal setup requires proper documentation

Submission:
Return this form to our office or email/fax it to: admin@1on1comprehensivehealthcare.com / (763) 402-7629