AUTHORIZATION AGREEMENT
DIRECT AUTOMATIC MONTHLY PAYMENT
VIA BANK DRAFT (EFT)

We____(CUSTOMER NAME) authorize GLOBAL SOURCE RX, INC. to electronically debit our BANK ACCOUNT indicated below. We authorize our bank account to be debited the (10th) of each month for the prior month's Statement Balance.

Practice Address:____

City:______________________________________ ST:___________ Zip:______________

Account Holder Name:____

Bank/Financial Institution Name:____

Bank Account Type: ☐ Checking ☐ Savings

Account Number:_______________________ Routing Number:_______________________

Bank/Financial Institution Address:____

City:______________________________________ ST:___________ Zip:______________

Email Address (for billing receipts):____

Specify min-max range of acceptable dollar amounts authorized:__________________________

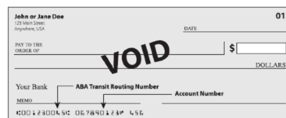
I understand that this authorization is to remain in full force and effect until I notify GLOBAL SOURCE RX, INC. in writing at Global Source RX, Inc., (7440 E. Karen Drive, Scottsdale, AZ 85260) that I wish to revoke this authorization. I understand that GLOBAL SOURCE RX, INC. requires at least five (5) days prior notice in order to cancel this authorization.

NAME:______________________________SIGNATURE:______________________________

JOINT ACCOUNT HOLDER (must sign if applicable)

NAME:______________________________SIGNATURE:______________________________

Please attach an original, voided, bank account check:



Email this form to: accounting@gs-rx.com

www.GS-Rx.com
7440 East Karen Drive, Suite #500 • Scottsdale, AZ 85260
(800) 833-4779 • 480-748-4545 • 480-748-4546(f)