BANK TO BANK MONTHLY TRANSFER PAYMENT
Authorization Form (ACH Debit)

Please choose one of the membership payment plans below (paid monthly):

Individual:	☐ $75
Couple*:	☐ $150
Family*:	☐ $225

* On back, please list full names and birth dates of any family members included in this membership.

Please complete the information below.

☐ Checking Account - OR- ☐ Savings Account

Bank Account Number _____

Bank Routing Number (9 digits) _____

Bank Name _____

Bank City and State _____

Name on account _____

Start date of debit(s): _____

Please sign the authorization below.

I hereby authorize The Doc Shoppe to electronically debit the bank account indicated above in accordance with my chosen payment plan. This authorization will remain in effect until I have provided seven days prior notification of cancellation to The Doc Shoppe in writing (1704 Forest Drive, Corbin, KY), by phone (606-620-9770) or email (Staff@TheDocShoppe.SpruceCare.com). This authorization shall extend to include any revised payment amounts which result from adding more members to my plan. I understand that the cost of membership(s) may change and I will be notified. I understand that additional costs may be incurred outside of my membership and I am responsible for these payments as well.

Name(s) *please print* _____

Signature _____ Date _____

If you are NOT paying today with a check from the account listed above, please attach a voided check or deposit slip for our records.