

Recurring ACH Payment Authorization

Business Name: _____

Business Address: _____

Contact Name: _____ Cell Phone: _____

E-mail: _____

By signing below, you acknowledge and accept the following terms and conditions for Recurring ACH Payments: (a) you are an authorized user for the account or card listed herein, (b) you authorize recurring withdrawals from the account or card listed herein, (c) you agree that no prior notification will be provided and ACH Payments will be withdrawn 4 - 7 business days after the invoice date, (d) in the case of a withdrawal being rejected for Non-Sufficient Funds (NSF) or any other bank stated reason a \$40 (non-refundable) fee will be added to the open balance, (e) there is a 4% processing fee for all credit/debit card transactions.

Printed Name: _____ Date: _____

Signature: _____

Send Completed Forms to: mluse@emsdetergent.com

Checking/Savings Account

****NEED A VOIDED CHECK****

Bank Name: _____ City/State: _____

Routing #: _____

Account #: _____

Credit/Debit Card

Card Type: _____ American Express _____ Discover _____ MasterCard _____ Visa

Cardholder's Name: _____

Card #: _____

Expiration Date: _____/_____
Month Year

CVV Code: _____
Code Next to Signature Panel