ECHO Health Inc
Pioneering Electronic Medical Payment Consolidation

Authorization & Guarantee Agreement for Automated Clearing House (ACH) Authority

Medical Service Provider:

Name _____

Billing Address _____

_____

Tax ID Number ☐☐☐☐☐☐☐☐☐

E-mail address _____

Additional e-mail address *(optional)* _____

Additional e-mail address *(optional)* _____

I will accept 1099s electronically ◉ Yes ○ No

If "yes," send to e-mail address shown _____

Medical Service Provider hereby authorizes ECHO Health Inc, hereinafter called "ECHO," to initiate credit entries for approved benefit plan payments to said Medical Service Provider's account identified hereinafter as "Depository."

I also understand that this authority is to remain in full force and effect until ECHO has received written notification from Medical Service Provider of its termination in such time and in such manner as to afford ECHO a reasonable opportunity to act on it, which in any way shall be not less than ten banking days after receipt.

BANK DEPOSITORY NAME _____

BANK DEPOSITORY ADDRESS _____

(address number, street)

_____

(city, state, zip code)

Transit / ABA No. ☐☐☐☐☐☐☐☐☐

(First number on account)

Account No. _____

(Second number on account)

Will ANSI 835s be received for automated posting? ◉ Yes ○ No

If "yes," provide Clearing House Name _____

Approval

Executed By *(print name)* _____ Title _____

Phone _____ Email _____

Date _____ Executed By *(signature)* _____

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