



DIRECT DEPOSIT AUTHORIZATION/REFUSAL

Refusal—*I would not be interested in participating in Direct Deposit at this time and I understand the PBSI is not responsible for lost or late checks via the US Mail. A paycheck will not be considered lost until Wednesday's mail of the following week arrives.*

Employee Signature

Initial Authorization

Change of Account Number

Change of Financial Institution

Name of Financial Institution

Phone Number

Mailing Address

City

State

Zip

Employee Name (Please Print)

Social Security Number

Checking Account

Account Number: _____

Savings Account

Routing Number: _____

I authorize Physician Billing Solutions, Inc. (PBSI) hereafter referred to as Employer, to deposit my periodic pay into my account identified as and held at the Financial Institution named above, and I authorize that such account exists and that the financial institution can make deposits without responsibility for correctness of such amounts.

This authorization will remain in effect until I give a written notice to terminate this authorization to my Employer in sufficient time and manner as to allow my employer to act upon it. In addition, either my Employer or the financial institute can terminate this agreement by providing me with their written notice at least 10 days prior to actual termination.

I have provided my Employer with a copy of a voided check solely for the purposes of verifying my account number and the Financial Institution's routing number.

Employee's Signature

Date

*******A VOIDED CHECK MUST BE ATTACHED HERE*******

*******FOR SAVINGS ACCOUNT ATTACH DEPOSIT SLIP*******