

# Automated Services LLC

## Auto-Pay Enrollment Form (Please select one):

- ☐ Pay by Credit Card – Please complete Sections A, B and C
- ☐ Pay by Electronic Check – Please complete Sections A, B and D

Please mail or fax the completed document to:

Attn: Account Services

7177 Miller Dr

Warren MI 48092

Phone: 586-751-9080

Fax: 586-979-8510

### Notice:

This authorization will remain in effect until such time that I contact Automated Services LLC in writing to request an alternative payment method. By signing below, I acknowledge that I have retained a completed copy of this authorization for my records.

## Section A: Customer Information

Office Name: \_\_\_\_\_ Accounts Payable Contact Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Accounts Payable Phone: \_\_\_\_\_ Accounts Payable Fax: \_\_\_\_\_

Email Address for Invoices: \_\_\_\_\_

## Section B: Transaction Type

## Section C: This if for accounting purposes only. TAX ID# or SS# is needed

☐ All Invoices

TAX ID#: \_\_\_\_\_

Social Security#: \_\_\_\_\_

## Section D: Credit Card Authorization

I hereby authorize Automated Services LLC. to charge the above transaction type using the credit card indicated below.

☐ American Express ☐ Visa ☐ MasterCard ☐ Discover

Card # \_\_\_\_\_ Expiration Date: \_\_\_\_\_ Security Code # \_\_\_\_\_

\* Security Code: MasterCard/Visa/Discover - 3 digit code located on signature strip. American Express – 4 Digit code on front of card.

Print Name as it appears on credit card: \_\_\_\_\_

### Credit Card Billing Address:

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Section E: ACH/EFT (Electronic Funds Transfer) Authorization

I authorize Genius Solutions Inc. to make variable withdrawals for the above transaction type(s) using the Depository Financial Institution (DFI) account indicated below and authorize said DFI to charge such withdraws to my listed account. It is agreed that these withdraws and adjustments may be made electronically and under the rules of the National Automated Clearing House Association and that the origination of ACH transactions to my account must comply with the provisions of U.S. law.

In the event that notice of Returned Funds is received from the DFI, a service charge of \$25.00 will be imposed and collected in addition to the original funds request submission.

### Depository Financial Institution Information (DFI):

Account Holder Name  
(e.g. Genius Medical, PLLC) Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Routing Number: \_\_\_\_\_ Account Number: \_\_\_\_\_

Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_

For Electronic Funds Transfer only, please include a copy of a blank, voided check.