Hendrick Clinic
CME Direct Deposit Authorization Form

	New Enrollment		Change Accounts

Name:	Lawson #

(Please attach a voided check.)

Primary Account Information

Please select type of account

1. Checking/Savings

Name of Financial Institution	Routing # (9digits)	Account #

I hereby authorize Hendrick Health to initiate entries to the account at the Financial Institution listed above and if necessary, initiate adjustments for transactions credited/debited in error. This authority will remain in effect until Hendrick Health is notified by me in writing to cancel it in such time as to afford Hendrick Health and Financial Institution a reasonable opportunity to act on it.

Signature: _____ Date: _____