



**VDx**<sup>®</sup>

Veterinary Diagnostics

Dr. John Peuroi, President  
DVM, MPVM, Dipl. ACVP

215 C Street, Suite 301  
Davis, CA 95616

Phone: (530) 753-4285  
Toll Free: (877) 753-4285  
Fax: (530) 753-4055  
www.vdxpathology.com

## **VDx – Automatic Payment Enrollment**

**To authorize automatic ACH payment of your monthly bill, please complete the form below. There is no additional charge to use this system.**

Clinic, Hospital or Account name: \_\_\_\_\_

VDx Account no: \_\_\_\_\_

My Bank name: \_\_\_\_\_ Branch: \_\_\_\_\_

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

Account holder name: \_\_\_\_\_

Routing number: \_\_\_\_\_ Bank Account number: \_\_\_\_\_

Account type:  Checking  Savings

Account SSN or taxpayer ID: \_\_\_\_\_

Email address: \_\_\_\_\_

*I hereby authorize VDX, Inc ("VDx", dba VDX – Veterinary Diagnostics and VDX – Preclinical, TID #68-0475320) to withdraw funds ("Debits") in the amount of my total monthly balance due from the Bank Account listed above. Funds will be withdrawn on or after the 20<sup>th</sup> of each month through the Automated Clearing House (ACH) system. I also authorize VDX to initiate deposits ("credits") to my Bank Account to correct any errors that may have been made with debits to my Bank Account. I authorize My Bank to process these debits from and credits to my Bank Account. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law.*

*I may cancel automatic payments at any time. This authorization will otherwise remain effective until I give VDX written notice to the contrary and VDX has had a reasonable period of time to act on that notice. My revocation of VDX's authority to initiate debits to my Bank Account will not affect VDX's right to initiate credits to my Bank Account to correct or adjust a debit processed before my revocation of authority has become effective.*

*I warrant to VDX and to VDX's Bank (First Northern Bank) that:*

*[ ] Only my signature is needed on this authorization to make it effective for my Bank Account.*

*[ ] Everyone whose signature is needed on this authorization to make it effective for my Bank Account has signed it.*

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Signature #2: \_\_\_\_\_

Print Name #2: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

*Return completed form by mail to VDX, 215 C Street, Suite 301, Davis, CA 95616 or fax to 530-753-4055.*

*-- DO NOT EMAIL FORM BACK --*