



ACH Debit Authorization Form

The purpose of this form is to authorize electronic debit transactions.

Customer Information

First Name *(As it appears on account)*

Last Name *(As it appears on account)*

Daytime Phone

Cell Phone

Email Address

I authorize the payment of:

Platinum Sponsorship
\$25,000

Gold Sponsorship
\$20,000

Silver Sponsorship
\$15,000

Cocktail Reception
\$15,000

Neuroanatomy Lab
\$15,000

Breakfast or Lunch
\$7,500

**Audience
Response App**
\$6,500

Coffee & Snack Bar
\$5,000

WiFi
\$5,000

Tote Bags
\$3,000

Charging Station
\$2,500

USB Lanyards
\$2,000

Notebooks
\$1,500

Pens
\$500

Effective Date

Dollar Amount

\$

Financial Institution being debited

Name of Financial Institution

Institution City

Institution State

Financial Institution 9 Digit Routing Transit Number

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Account Number to Debit

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I hereby authorize The Headache Center Institute (TIN: 83-1389740) to initiate a charge (debit) entry at the Financial Institution indicated above, and initiate adjustments (if necessary) for any transactions debited in error. I agree that each payment shall be the same as if it were an instrument personally signed by me. This authority is to remain in effect until revoked by me in writing.

I understand, that both the Financial Institution and The Headache Center Institute (TIN: 83-1389740) reserve the right to terminate this payment plan.

Please attach a copy of a voided check and email to:

ctreppendahl@mississippimigrainecenter.com

Signature

Date