

## Direct Payment Authorization Form

BHSH is now offering a more convenient way to make your monthly payments without having to incur the time and cost of writing and mailing a check. Print this form to enroll in our Direct Payment Plan. If you have any questions call 721-4900.

All you need to do is:

1. Mark the box of the type of account to indicate whether your payment will be deducted from your checking or savings account.
2. Mark the box of which date you would like to have your payment withdrawn from your account.
3. Fill in your name, financial institution name and location and date.
4. **Attach a voided check** for verification of all financial institution information. If you are unable to attach the voided check, please fill in your account number and routing number.

**NOTE: Be sure to sign the form!**

### AUTHORIZATION FOR DIRECT PAYMENT

I authorize Black Hills Surgical Hospital to initiate electronic debit entries to my:  checking account or  savings account for payment on account number: \_\_\_\_\_ on the  1<sup>st</sup> of the month or  15<sup>th</sup> of the month for \$ \_\_\_\_\_ per month. I understand I will receive a notice if the amount changes.

I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. This authority will remain in effect until (date) \_\_\_\_\_ or until I have cancelled it in writing.

Date \_\_\_\_\_

Financial Institution Name (Please Print) \_\_\_\_\_

Account Number at Financial Institution \_\_\_\_\_

Financial Institution Routing/Transit Number \_\_\_\_\_

Financial Institution City and State \_\_\_\_\_

Signature \_\_\_\_\_

*\*\* If the 1<sup>st</sup> or 15<sup>th</sup> falls on a weekend or holiday, the funds will be debited on the next business day.*

**Mail or hand deliver this completed form to:**

Black Hills Surgical Hospital  
1868 Lombardy Drive  
Rapid City, SD 57703  
Attn: Patient Accounts

**PLEASE KEEP A COPY OF THE AUTHORIZATION FOR YOUR RECORDS.**