AUTHORIZATION AGREEMENT
DIRECT PAYMENTS (ACH DEBITS)

I (we) hereby authorize CHASE COUNTY COMMUNITY HOSPITAL/CLINIC, herein after called CCCH, to debit entries to my (our) account indicated below and the FINANCIAL INSTITUTION named below, herein after called INSTITUTION, to debit same to such account. I (we) acknowledge the origination of ACH transactions to my (our) account must comply with the provisions of U. S. law.

_____ _____
(Financial Institution Name) (Branch/City)

(Address) (City) (State) (Zip)

_____ _____ Type of Account ___Checking ___Savings
(Routing/Transit Number) (Account Number)

Date of withdrawal ___10th of the month ___ 20th of the month

Amount of withdrawal per month $_____Hospital

$_____Clinic

This authority includes all self-pay accounts at Chase County Hospital/Clinic for this guarantor. This authority is to remain in force and effect until CCCH has received written notification from me (or either of us) of termination in such time and manner as to afford CCCH and INSTITUTION a reasonable opportunity to act upon it. If my bank account is overdrawn, I understand that my account at CCCH is subject to collection policies. An overdraft fee of $20 will be added to my account.

_____ _____
(print individual name) (print individual name)

_____ _____
(signature) (date) (signature) (date)

PLEASE ATTACH A VOIDED CHECK TO THIS FORM