



Direct Deposit Agreement Form

Authorization Agreement

I hereby authorize **The CHP Group** to initiate automatic deposits to my account at the financial institution named below. I also authorize **The CHP Group** to make withdrawals from this account in the event that a credit entry is made in error.

Further, I agree not to hold **The CHP Group** responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or by my financial institution or due to an error on the part of my financial institution in depositing funds to my account.

This agreement will remain in effect until **The CHP Group** receives a written notice of cancellation from me or my financial institution, or until I submit a new direct deposit form to the Provider Services Department.

Account Information

If you are a provider paid by your clinic as an employee, please forward this form for completion by the person responsible for direct deposit into the clinic's account.

Name of Company/Provider: _____

Name on Account: _____

Name of Financial Institution: _____

Routing Number: _____ Checking

Account Number: _____ Savings

Signature

Authorized Signature (Primary): _____ Date: _____

Printed Name: _____

Authorized Signature (Joint): _____ Date: _____

Printed Name: _____

Please attach a voided CHECK and return this form to the Provider Services Department:

**Attn: Provider Services
The CHP Group
6600 SW 105th Ave Ste 115
Beaverton OR 97008**

ATTACH VOIDED CHECK HERE