Ambiance Home Health Care, Inc.

Direct Deposit Agreement Form

Please indicate if this is a new request or a change:

Date:_____ ☐New ☐Change

Authorization Agreement

I hereby authorize **Ambiance Home Health Care, Inc.** to initiate automatic deposits to my account at the financial institution named below. If every **Ambiance Home Health Care, Inc.** to withdraw the overpayment after notifying me.

Further, I agree not to hold **Ambiance Home Health Care, Inc.** 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 **Ambiance Home Health Care, Inc.** receives a written notice of cancellation from me or my financial institution, or until I submit a new direct deposit for to **Ambiance Home health Care, Inc.** Employees/Contractors must fill out all the information below and **submit it with a copy of a voided check or deposit slip.**

Account Information

Name of Financial Institution: _____

Name & Address of Financial Institution _____

Routing Number:_____ ☐Checking ☐Savings

Account Number:_____

Email Address for Notification of Deposit _____

Signature

Print Name:_____

Authorized Signature ✘ _____

Please return this form to:

Ambiance Home Health Care, Inc.
7825 N. Dale Mabry Hwy Suite 104
Tampa, FL 33614
Fax: (813) 793-4684