Check Draft Authorization Form

_____authorizes Ixthus Medical Supply, Inc. to initiate funds from our Checking
(Store Name)
Account. The account indicated on each faxed check will be used for the corresponding invoice. In addition, permission is given to my depository financial institution to honor these transfers.

Please Check One Box (required)

☐	This is an open authorization to allow debits to my account for amounts which will vary per transaction based on the order amount. I will fax a check for each transaction
☐	This authorization is valid for this transaction only. The transaction amount will be $ _____ (transaction amount required)

I have read and agree to all of the terms and conditions on this page and any other contract or document that accompanies this agreement. I certify that I am the authorized account holder for this checking account. I understand this is a binding agreement and I will receive a copy of each check draft in my statement when the item has cleared.

I understand this is a legal binding agreement between Ixthus Medical Supply & _____
I understand that all returned checks are subject to a $25.00 NSF Fee. This agreement will remain in effect until Ixthus Medical Supply, Inc. receives my written notice of cancellation via mail, fax or email.

_____ _____
Authorized Accountholder Signature (required) Date (required)

Fax this form **and** your completed check to 262-878-9009
(required)

Ixthus Medical Supply, Inc.

Print Form