Ixthus Medical Supply, Inc.

AUTHORIZATION AGREEMENT FOR DIRECT PAYMENTS (ACH Debit & Credit)

I (We) hereby authorize Ixthus Medical Supply, Inc, hereinafter called Company, to initiate debit/credit entries to my (our): Checking Account ☐ Savings Account ☐ (select one) indicated below at the depository financial institution named below, hereafter called Depository, and to debit/credit the same to such account. I (we) acknowledge that the origination of Automated Clearing House (ACH) transactions to my (our) account must comply with the provisions of U.S. law.

Additionally, I (we) hereby authorize Company to initiate credit entries to my (our) account and the Depository to debit the same to such account, in the case where the incorrect amount has been debited to such account in error.

This authority is to remain in full effect until Company or Depository has received written notification from me (or either of us) of its termination in such time and manner as to afford Company or Depository a reasonable opportunity to act on it, or until Company or Depository has sent me (either of us) ten (10) day written notice of Company or Depository's termination of this agreement.

Depository Name	Address		
City		State	Zip

Depository's Transit Routing Number

Account Number Information

Company Name

Signed

Date

Please Print, Sign and Fax this form to 262-878-9009

Print Form

Note: Written debit authorizations MUST provide that the receiver may revoke the authorization only by notifying the originator in the manner specified in the authorization.