PO Box 218 Mt Vernon WA 98273 • PH: 360-424--7147 • **FAX: 360 848-1587**

Customer#_____

Client's Name: _____

Address:_____

City:_____ St ___ Zip_____

Ph: _____ Fax: _____ Email:_____

Invoice total to be deducted

Automatic Payment Plan
(Attach Voided Check)

Account Information:

Bank Name: _____

Routing Number: _____

Checking Account Number _____

I/we authorize **Food Services, Inc.** to electronically debit the above account in accordance to the schedule completed above. I/we understand that should the debit to the account be returned by the bank due to NSF or other reasons, that Food Services, Inc. will initiate a replacement debit to the account, along with a **separate and additional NSF fee debit** to the account**.** The signature below indicates understanding and acceptance of this checking policy.

Signature: _____ Date: _____

Print Name_____