ASA - Direct Deposit Authorization

Choose: _______Member ________Residential Provider

Location: _______GJ _______DR _______CS

I authorize Ariel Clinical Services to send credit entries, as well as appropriate adjustments and debit entries, to my/our account as indicated below.

Account Type: ______Checking ______Savings Institution

Name: ____ Bank

Routing #/ ABA #: ____________________________

Account#: ____________________________________

Account verification must be submitted with this form, and not in lieu of it.

Please Attach:
Voided Check or Account Verification Form/Letter issued by your bank.

Verification must include:

1. Bank Letterhead/Logo, Address and Routing Number
2. Name on Account, Account Number, Type of Account

Signature: ____Date: ________________________

Printed Name: ____

Email Address for Notifications (optional): ____