COAXION
RADIOLOGY SOLUTIONS

Direct Deposit Enrollment

1. **IMPORTANT – Please read and sign before completing and submitting**.

   I hereby authorize Coaxion Radiology Solutions to deposit and amounts owed me by initiating credit entries to my account at the financial institution (hereinafter "Bank") indicated on this form. Further, I authorize Bank to accept and to credit and credit entries indicated by Coaxion Radiology Solutions to my account. In the event Coaxion Radiology deposits funds erroneously into my account, I authorize Coaxion Radiology Solutions to debit my account for an amount not to exceed the original amount of the erroneous credit. This authorization is to remain in full force and effect until Coaxion Radiology Solutions has received written notice from me of its termination in such time and in such manner as to afford Coaxion Radiology Solutions reasonable opportunity to act on it.

   Name:_____ Date: _____

   Signature: _____

2. **Attach a voided check for each checking account – not a deposit slip**.

   If depositing to a savings account, ask your Bank to give you the Routing. Transit Number for your account. It isn't always the same as the number on the savings account deposit slip. This will help ensure you are paid correctly.

3. **Complete the account information below**.

   Account Type: Checking Savings

   Bank Name & Address: _____

   _____

   _____

   Account Holder Name: _____

   Bank Routing #: _____

   Bank Account #: _____