ACH or Credit Card Recurring Payment Authorization Form

Mail to Remit address. DO NOT EMAIL.

Remit address: Triangle Medical Solutions, PO BOX 815, Bethel Park, PA 15102

Schedule your payment to be automatically deducted from your checking or credit/debit card.
Just complete and sign this form to get started!

Recurring Payments Will Make Your Life Easier:

- It's convenient (saving you time and postage)
- Your payment is always on time (even if you're out of town), eliminating late charges.

Here's How Recurring Payments Work:
You authorize regularly scheduled charges to your checking or savings account. You will be charged the normal monthly fee each billing period plus any special fees. You will receive notice 2 days before the payment is posted, with the amount to be collected and date it will be collected. Usually this schedule would be between the 3rd and 7th of the month.

Please complete the information below:

I, ______________________________, authorize Triangle Medical Solutions to charge my bank account
(full name)

or credit/debt card during the first week of a month for full payment of my FastEMC bill.

Billing Address ______________________________ Phone#: ______________________________

City, State, Zip ______________________________ **Email:** ______________________________

Checking Account Type: ☐ Checking ☐ Savings

Name on Acct ______________________________

Bank Name ______________________________

Account Number ______________________________

Bank Routing # ______________________________

Bank City/State ______________________________

Credit/ Debit Account Type: ☐ Discover ☐ Visa ☐ MasterCard ☐ American Express

Name on Card ______________________________

Company Name ______________________________ Required if ☐ Commercial Card

Credit Card Number ______________________________

Expiration Date ______________________________ CVV Code ______________

Billing Address ____

City, State ______________________________ Zip ______________________________

SIGNATURE ____ DATE ____________________

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Triangle Medical Solutions in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted periodic payment dates fall on a weekend or holiday, I understand that the payment may be executed on the next business day. I understand that because this is an electronic transaction, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Non Sufficient Funds (NSF) I understand that Triangle Medical Solutions may at its discretion attempt to process the charge again within 30 days, and agree to an additional $25 charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I agree not to dispute this recurring billing with my bank so long as the transactions correspond to the terms indicated in this authorization form.