



Mt Vernon WA 98273 • PH: 360-424-7147 • FAX: 360 848-1587

Customer# _____

Client's Name: _____

Address _____

City _____ WA Zip _____

Ph _____ Fax _____ e-mail _____

Invoice total to be deducted weekly for previous wks invoice

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 in the amount of **\$50.00**. The signature below indicates understanding and acceptance of this checking policy.

Signature: _____ Date: _____

Print Name _____