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**AUTHORIZATION FOR
DIRECT DEPOSIT VIA PAYPAL**

I hereby authorize NEXPC1 LLC (dba AFC URGENT CARE) ("COMPANY") to electronically credit my Paypal account identified below. I agree that ACH transactions I authorize via Paypal comply with all applicable law.

Please use the following to identify my Paypal account (check one and print clearly):

My email address: _____

My mobile number: _____

Paypal's confirmation of deposit of funds to my Paypal account identified above will serve as my written acknowledgment that I have personally received a payment of the deposited amount from COMPANY, as of the date of deposit to my Paypal account. To the extent that I provide incorrect Paypal account information above, I accept responsibility for such error and release COMPANY of any further obligation to pay me the amount of funds deposited by COMPANY to such incorrectly identified Paypal account.

I understand that this authorization will remain in full force and effect until I notify COMPANY in writing, that I wish to revoke this authorization. I understand that COMPANY requires at least five (5) business days prior notice in order to cancel this authorization.

Patient name(s): _____

Payee's name: _____
(If other than patient, e.g. parent, guardian or guarantor)

Payee Signature: _____ Date: _____

PLEASE TRANSMIT SIGNED AUTHORIZATION TO AFC URGENT CARE VIA ABOVE FAX# OR EMAIL