Gragil Associates, Inc.
Accounts Receivable Management

# RECURRING PAYMENT AUTHORIZATION FORM

Date: _____

Name: _____

Address: _____

_____

Re: Client: _____

Date of Service: _____

Ref # _____

Original Balance: _____

Acct# _____

I authorize Gragil Associates, Inc. to withdraw/debit my account indicated below $ _____
{ } weekly, { } biweekly, { } monthly starting on _____ until my account is paid in full.

☐ Checking

Name on Acct _____

Address on Check _____

Bank Routing # _____

Last 4 Digits of Acct # _____

☐ Visa ☐ MasterCard

☐ Amex ☐ Discover

Cardholder Name _____

Last 4 Digits of Acct # _____

Exp. Date _____

CCV (3 digit number on back of card) _____

****Please contact our office at 1-800-336-0299 with your complete checking/credit card account number.**

Signature _____ Phone# _____

**Form can be emailed, mailed or FAXED to:**

Gragil Associates, Inc.
P.O. Box 1010
Pembroke, MA 02359
FAX: 781-826-6367
collections@gragil.com

THIS COMMUNICATION IS FROM A DEBT COLLECTOR. THIS IS AN ATTEMPT TO COLLECT A DEBT. ANY INFORMATION OBTAINED WILL BE USED FOR THAT PURPOSE.