



Authorization and Agreement

This form completed in its entirety will authorize Advanced Medical Transport to deduct payments from your checking account.

I hereby authorize Advanced Medical Transport to instruct my bank or the financial institution named in this application to make my payment from the account listed as they are due. I understand that I am in full control of automatic payments. I may discontinue enrollment at any time by calling Advanced Medical Transport @ (309) 494-6203 or (855)268-2455. If I have signed up for monthly payments and need to stop them for any reason I can.

Simply complete the form on the back and either mail it back to:

Advanced Medical Transport

1718 N Sterling Avenue

Peoria, IL 61604

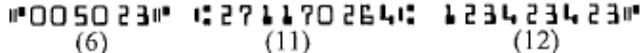
Or

fax it to: (309) 494-6537

Monthly payments of: _____ to be taken on this day of the month: _____
(If this date falls on a weekend, your payment will be processed on the following Monday.)

If your bank or financial institution denies your payment, we will attempt to process it for 3 consecutive days. On the 4th day, you will receive a collection notice if we haven't had any contact with you for a resolution.

Signature: _____ Date: _____

(1) Your Name (2) Your Address (3) Your City, State, Zip	(4) First Bank of USA (5) Bloomington, IL (7) 70-7026/2711	(6) 0523 12/31/98
Pay To The Order of _____		\$ _____ (8)
Dollars _____		
Memo: (9) _____ (10) _____		
 (6) (11) (12)		

(1) Name or Company on check: _____

(2) Address: _____

(3) City, State, Zip: _____

(4) Bank Name: _____

(5) Bank City/ State: _____

(6) Check Number: _____

(7) A. B. A. Number: _____

(8) Amount of Check: _____

(9) This check is for what patient name: _____

(10) Authorized by: _____

(11) Transit Number: _____ (Always 9 digits beginning with 0,1,2 or 3)

(12) Account Number: _____

Phone #: _____

Account/Run #: _____

Additional Comments or Special instructions: _____