BANK TRANSFER AUTHORIZATION FORM

I authorize InterpStudies, LLC to electronically debit my bank account
$69.00 for home sleep study interpretations.

CUSTOMER BANK ACCOUNT INFORMATION:

Account type: ___Checking ___Savings ___Consumer ___Business

Routing number
Account number
Name/Business on account

Name(s) of Ordering Doctors		*Circle one* DMD/DDS
Practice name		

Practice address

Street		
City	State	Zip
Phone number	Fax number	
Email Address (*Required for Receipts*)		

Billing address

Street		
City	State	Zip

By signing this document, you authorize InterpStudies, LLC to electronically debit your bank account for completed physician interpretations of home sleep studies obtained through our company.

Account holder's signature____

Date____

Please email or fax to: interpstudies@gmail.com (585)-394-6524

InterpStudies, LLC
5114 State Route 21 South
Canandaigua, NY 14424

Please contact the Billing Department at 585-394-6524 with any concerns.