SBG® Staffing Solutions for Employers of Physicians & Advanced Practitioners
HEALTHCARE
QUALITY INTEGRITY SERVICE • QUALITY INTEGRITY SERVICE • QUALITY INTEGRITY SERVICE

Direct Deposit Agreement Form

Provider Name:

Authorization Agreement

I hereby authorize SBG Healthcare to initiate automatic deposits to my account at the financial institution named below. I also authorize SBG Healthcare to make withdrawals from this account in the event that a credit entry is made in error.

Further, I agree not to hold SBG Healthcare responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or by my financial institution or due to an error on the part of my financial institution in depositing funds to my account.

This agreement will remain in effect until SBG Healthcare receives a written notice of cancellation from me or my financial institution, or until I submit a new direct deposit form to the Credentialing Department.

Account Information

Name of Financial Institution: _____

Routing Number: _____

Account Number: _____ ☐ Checking | ☐ Savings

Signature

Authorized Signature (Primary): _____ Date: _____

Authorized Signature (Joint): _____ Date: _____

Please attach a voided check or direct deposit bank document and return this form to the Credentialing Department for processing.