



Authorization for Automatic Withdrawal

Automatic payments will occur on a monthly basis and process on the 16th of the month for the current month's service. If this processing date is an issue please let our office know and we can adjust to a date that better accommodates your needs.

Customer Information

Full Name _____ Phone Number _____

Address _____ Account Number _____

Email Address _____

Financial Information (either bank account or credit card)

Bank Account-

Name of Institution _____ Phone Number _____

Routing Number (9 digits) _____ Account Number _____

*If selecting a bank account please attach a voided check or bank letter confirming account information.

Credit Card-

Type of Card Visa Mastercard Discover

Name on Card _____ Billing zip code _____

Card Number _____ Exp Date _____

CSC Code (last 3 digits on back) _____

New Authorization Statement

I authorize Capital City Refuse, Inc. to charge the above account for the amount due for monthly services on the 15th of every month. I understand that charges due to NSF, errors in documentation or other additional fees, will be charged to the above mentioned account. I understand that container(s) provided and placed on my premises for services provided by Capital City Refuse, Inc. are to be stored / secured / kept contained and are my responsibility. I may terminate this agreement at any time by notifying Capital City Refuse, Inc. via phone or email, allowing reasonable time for them to act upon my request for termination. I understand that the agreement will be terminated upon receipt of any balances due. I hereby authorize Capital City Refuse, Inc. to initiate both debit and credit adjustments for services provided.

Customer Signature _____ Date _____

Upon completion of this form please return to our office at
cerefuseinc@gmail.com ~or~ PO Box 499 Walton NE 68461