



American  
Chiropractic  
Association

# E-Z PAY SIGN-UP FORM

Reinstatement

Current Member Dues Payment

Category Change indicate NEW category below

ACA Membership ID _____		Membership Category _____	
First _____	Middle _____	Last _____	Suffix _____
<input type="checkbox"/> Address Update (note new address below if changed)			
Clinic Name _____			
Address _____		Ste/Apt _____	
City _____	State _____	Zip _____	
(____) _____	(____) _____		
Phone _____	Fax _____		
E-Mail (For ACA Communications only) _____			

Annual Dues \$ \_\_\_\_\_

**Additional Contributions**

NCLAF \$ \_\_\_\_\_

PAC \$ \_\_\_\_\_

ACF \$ \_\_\_\_\_

**Total Amount \$**

## Payment Information (U.S. Funds Only)

Please complete payment authorization below and enclose voided check for checking account debit

**EZ PAY\* (Account Debit Program)**

Checking     Monthly

Bank Name: \_\_\_\_\_

Account #: \_\_\_\_\_

ABA Routing #: \_\_\_\_\_

Credit Card     Monthly     Quarterly     Semi-Annually     Annually

Name on card: \_\_\_\_\_

Card #: \_\_\_\_\_

Exp Date: \_\_\_\_\_ Security Code: \_\_\_\_\_ Amt. to Charge: \_\_\_\_\_

I hereby authorize the American Chiropractic Association to initiate on or about the 15th of each month, debit entries to my checking account as indicated above (or on the attached voided check) or my credit card account. I hereby authorize the depository institution named above to debit the same from my account. Said debits shall be for the amount of my monthly, quarterly, semi-annual or annual dues payments. I understand that the amount will be adjusted by ACA if I change my ACA membership classification or if any applied discount expires. This agreement will remain in effect unless I notify ACA, in writing, to cancel it.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Fax form to Member Services at (703) 243-2593 or mail to ACA, 1701 Clarendon Blvd, Arlington, VA 22209  
 Questions? email [MemberInfo@acatoday.org](mailto:MemberInfo@acatoday.org) or call 1-800-986-4636