

Medical INK Corporation

Automatic Credit Card Billing Authorization Form

If you would like to enjoy the convenience of payment using your credit card, simply complete the Information below, sign and return the form to us by mail, fax or e-mail. All information is required.

US MAIL: Medical INK Corporation, 3350 Village Walk Circle, Naples, FL 34109

FAX: 1-800-778-6643

E-MAIL: office@medical-ink.com

_____ 1. Automatic Payment Authorization. Ten days after my monthly invoice is issued by Medical INK Corporation, I authorize Medical INK Corporation to automatically charge my credit card for the amount of the current invoice and understand that the total charges will appear on my monthly credit card statement. I understand that I may cancel this automatic billing authorization at any time by contacting Medical INK Corporation in writing.

_____ 2. Single Payment Authorization. I authorize Medical INK Corporation to bill my credit card as specified below.

CLIENT INFORMATION	
Client name: _____	Telephone Number: _____
	Client E-mail: _____

PAYMENT INFORMATION	
I authorize Medical INK Corporation to automatically bill the card listed below as specified:	
Amount: \$ _____	or <input type="checkbox"/> Monthly amount shown on Medical INK Invoice
Start billing on: _____ / _____ / _____	End Billing when client provides written cancellation

CREDIT CARD INFORMATION		
Medical INK Corporation accepts Visa and MasterCard only		
This will authorize Medical INK Corporation to initiate credit card payments as listed. This authorization will remain in force until Medical INK Corporation has received written notice of its termination and has provided to client a written confirmation of receipt said notice in such time and in such manner as to afford Medical INK Corporation a reasonable opportunity to act following confirmation of receipt of termination. This authorization does not change payment terms. Medical INK Corporation reserves the right to revoke this authorization in the event of a dispute of the charge without prior notification from the client; account closed or changed without prior notification from the client and/or two or more declined transactions in one year. Reinstatement may be considered after six months.		
Credit Card Type: _____	Credit Card Number: _____	Expires: _____ / _____
Please provide the three digit security number appearing on the back of your credit card (required) : _____		
Cardholder's name as shown on the credit card: _____	Cardholder's Zip Code from credit card billing address (required): _____	
Client's signature: _____	Date: _____	