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@medink.com

Client Name: _____

Client Telephone #: _____

Client Email: _____

Please check one:
_____ VISA _____ MASTERCARD

Cardholder's name as shown on card: _____

Credit card number: _____

Expiration date _____ 3 digit security code _____ (usually located on the back of your card).

Credit Card Billing Address: _____

_____

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.

Please start billing on: _____.

_____ Date: _____
Signature

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.