



## ACH / Credit Card Payment Authorization

- o **Recurring Charge** – You authorize regularly scheduled charges to your Credit Card or Bank Account. You will be charged the amount indicated below each billing period:  Weekly  Bi-Weekly  Monthly.  
A receipt for each payment will be provided to you and the charge will appear on your Credit Card or Bank Account Statement via  Text or  Email.

Please provide cell phone #: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_ or email address \_\_\_\_\_@\_\_\_\_\_.com  
You agree that no prior notification will be provided unless the date or amount changes, in which case you will receive a notice from us at least 14 days prior to the payment being collected.

I \_\_\_\_\_ authorize MedFusion Inkk, LLC to charge my Credit Card or Bank Account below for \$\_\_\_\_\_.00 beginning on \_\_\_\_\_ (Date).

Goods / Services Rendered: \_\_\_\_\_.

- o **One (1) Time Charge** – You authorize the merchant below to make a one-time charge to your Credit Card or Bank Account listed below.

By signing this form, you give us permission to debit your account for the amount indicated on or as the indicated date. This is permission for a single transaction only and does not provide authorization for any additional unrelated debits or credits to your account.

I \_\_\_\_\_ authorize MedFusion Inkk, LLC to charge my Credit Card or Bank Account indicated below for \$\_\_\_\_\_.00 on \_\_\_\_\_ (Date).

Goods / Services Rendered: \_\_\_\_\_.

### Billing Details

Billing Address \_\_\_\_\_ Phone# \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Email \_\_\_\_\_

### Credit Card Information

Visa  MasterCard  Amex  Discover

Cardholder Name: \_\_\_\_\_ Credit Card#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Expiration Date: \_\_\_\_/\_\_\_\_ Security Code (CVV): \_\_\_\_\_

### Bank (ACH) Information

Checking Account  Savings Account

Name on Account: \_\_\_\_\_

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

Acct#: \_\_\_\_\_ Routing#: \_\_\_\_\_

*I understand that this authorization will remain in effect un/ I cancel it in writing, & I agree to notify the merchant in writing of any changes in my account information or termina/on of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. For ACH debits to my checking/savings account, I understand that because these are electronic transaction dates. In the case of an ACH Transaction being rejected for Non-Sufficient Funds (NSF) I understand that the merchant may at its discretion attempt to process the charge again within 30 days & agree to an additional \$45 authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card/bank account & will not dispute these scheduled transitions with my bank; so long as the transactions correspond to the terms indicated in this authorization form.*

Printed Name: \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/20\_\_\_\_

Signature \_\_\_\_\_