# X-medics A/S - Credit Card Authorization Form
# (Please return to sales@x-medics.com)

## CARDHOLDER INFORMATION

Name:_____

Billing Street Address:_____

Street Address (cont.):_____

City:_____ State:_____ Postal Code:_____

Country:_____ Email _____

Address:_____

Direct Telephone: (_____)_____-_____

## ORDER INFORMATION

PO #:_____

□ I authorize a one-time charge against my credit card for the follow amount $ / € _____ (+ 3% fee)

□ I authorize future charges against my credit card for amounts as specified on Purchase Orders issued to your firm

## CREDIT CARD INFORMATION

Credit Card Type: □ MasterCard □ Visa

Card Holder Name:_____

Credit Card Number:_____

Billing Address (include zip code):_____

Expiration Month:_____ Expiration Year:_____Security Code:_____

## Authorization:

I hereby authorize X-medics A/S to charge the indicated credit card plus a transaction fee of 3%. I agree that this is either a one time or periodic charge that will be made as indicated above. To terminate the recurring billing process, if selected, I must cancel in writing. I understand that all account cancellations must be made in writing. I will not dispute the recurring billing with my credit card issuer so long as the amount in question was for services rendered prior to my canceling my account in the manner required. I guarantee and warrant that I am the legal cardholder for this credit card and that I am legally authorized to enter into this one time or recurring billing agreement.

Cardholder Signature X_____ Date___/___/___