Credit Card Payment Authorization Form

Please complete this form and fax back. By completing this form, you authorize Flex Endo to make a debit to your credit card listed on this form. Fax: 248-847-3976.

Please complete the following:

I ________________________________ authorize Flex Endo to charge my account for $__________ on or

after __________________. This payment is for (Purchase order number or product to be listed)

_______________________________.

Billing Address:_____________________________ Phone:_____________________________

City, State, Zip:______________________________ Email:_____________________________

Card Type: [] Visa [] Mastercard [] Amex [] Discover

Cardholder Name:____

Card Number:____

Experation Date:_________________________ CVV2 (3 digit code, 4 digit for Amex)_____

PLEASE NOTE: 3% Convenience fee for all credit card sales!!!!

SIGNATURE:____ Date:________________________________

6421 Inkster Rd STE 102 Bloomfield TWP MI 48301