6111 Jackson Rd., Suite 200
Ann Arbor, MI 48103
734-327-2946
Fax: 734-327-3715
axiobionics.com

CREDIT CARD AUTHORIZATION AND RECURRING PAYMENT FOR PURCHASES FORM

This form grants AxioBionics, LLC authorization to charge the patient's credit card for the indicated service/device. All requested information is required. Upon approval, we will bill your credit card for the amount indicated and your total charges will appear on your credit card statement. Any changes to your credit card information must be communicated to AxioBionics in a timely manner.

Your credit card may be charged for: 1) One-time purchases or trials, 2) Recurring purchases, or 3) Automatic recurring billing for rented or trial equipment.

TERMS OF SERVICE FOR RENTAL, RENT-TO-PURCHASE, AND NON-RETURNABLE ITEMS:
Borrower shall be responsible for proper use of the equipment. Borrower is responsible for the full cost of repair or replacement of any or all equipment that is damaged, lost, or stolen from the time borrower assumes custody until it is returned to AxioBionics. Borrower shall be responsible for the safe packaging and shipping, if needed, of the equipment. If equipment is not returned within 7 days after end date of trial period, borrower shall be charged an additional month of rental. Borrower will incur additional rental charges for each month thereafter until equipment is returned. AxioBionics reserves the right to charge the full purchase price of any equipment not returned. An extension of the trial period must be coordinated with AxioBionics prior to the original end date of the trial period. Equipment shall be returned to: AxioBionics, 6111 Jackson Rd. Suite 200, Ann Arbor, MI 48103.

PATIENT INFORMATION

Patient Name *(print)* _____ Patient # *(Office Use)* _____

Authorized Representative *(print)* _____ Relationship to Patient _____

PAYMENT INFORMATION

Service/Device Description _____

Serial # _____ Trial or Rental Start Date _____ Trial or Rental End Date _____

Total Amount _____ Recurring Payment Amount _____

Frequency: ☐ N/A ☐ Monthly ☐ Other: _____

FIRST PAYMENT ON: _____ LAST PAYMENT ON: _____ ☐ No End Date

Start Date *(month/day/year)* _____ End Date *(month/day/year)* _____

CREDIT CARD INFORMATION

Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ American Express ☐ Other: _____

Card Holder's Name *(as shown on card)* _____ Credit Card Billing Zip Code _____

Card Number _____ Expires On *(month/year)* _____ Card Security Code *(CVV)* _____

Card Holder's Email _____ Card Holder's Phone _____

I (patient/authorized representative) grant AxioBionics, LLC authorization bill the credit card listed above as specified.

Patient or Authorized Representative *(print)* _____ Signature _____ Date _____

☐ Verbal Authorization granted by Card Holder

AxioBionics Representative _____ Date _____