595 N Smith Street
Corona, CA 92880
Phone: (951) 270-0816
Fax: (951) 582-2693

CREDIT CARD & BANK DEBIT CARD AUTHORIZATION FORM

TO PAY BY CREDIT CARD, PLEASE COMPLETE THE FOLLOWING INFORMATION IN ITS ENTIRETY:

Account Information

Practice/Doctor Name: _____ Account #: _____

In lieu of my credit card imprint, I, _____

(Name of Cardholder as it appears on Credit Card)

Hereby authorize Aidarex Pharmaceuticals, LLC to charge my order(s) to the following card:

○ VISA ○ MasterCard ○ AMERICAN EXPRESS ○ DEBIT CARD

Card Number: _____ Exp Date: ____/____ CVV2: _____

BILL TO ADDRESS AS IT APPEARS ON MY CREDIT CARD STATEMENT

CONTACT: _____

ADDRESS 1: _____

ADDRESS 2: _____

CITY: _____ STATE: _____ ZIP: _____ COUNTRY: _____

PHONE: _____ EMAIL FOR RECEIPT: _____

CARDHOLDER'S AUTHORIZED BILLING AMOUNT: I HEREBY AUTHORIZE AIDAREX PHARMACEUTICALS, LLC TO BILL MY CREDIT CARD FOR CHARGES PERTAINING TO INVOICES SPECIFIC TO MY ACCOUNT.

I WOULD LIKE MY CARD TO BE CHARGED: ○ UPON ORDER SHIPMENT

○ NET 30 TERMS

BY SIGNING THIS FORM I ACKNOWLEDGE AND AGREE TO THESE TERMS AND CONDITIONS. I ALSO AGREE TO WAIVE ANY CHARGE-BACK RIGHTS IN THE EVENT OF A DISPUTE. REQUESTS FOR A REFUND MUST BE SUBMITTED IN WRITING ALONG WITH ALL APPLICABLE ORDER DOCUMENTATION IN ACCORDANCE WITH THE STANDARD POLICIES OF THE COMPANY WHO ISSUED THE CREDIT CARD.

Signature: _____ Date: _____

Print Name: _____ Title: _____

(THIS FORM MUST BE COMPLETED IN FULL AND ALL INFORMATION MUST BE TRUE AND CORRECT IN ORDER FOR PAYMENT TO BE PROCESSED.)