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

RECURRING PAYMENT / CREDIT CARD AUTHORIZATION FORM

If you would like to enjoy the convenience of automatic recurring billing, simply fill out and sign the form below. All requested information is required. Upon approval, we will automatically bill your credit card for the amount indicated and your total charges will appear on your monthly credit card statement. Any changes to your credit card information must be communicated to AxioBionics in a timely manner. You may make additional payments at any time to lower your remaining balance.

PATIENT INFORMATION

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

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

PAYMENT INFORMATION

Service/Device Description _____

Serial # _____ FROM _____ TO _____ Trial Duration

TERMS OF SERVICE:
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.
Equipment shall be returned to: AxioBionics, 6111 Jackson Rd. Suite 200, Ann Arbor, MI 48103.

Recurring Amount _____ Other _____

Frequency: ☐ 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)* _____

Card Number _____ Expires On *(month/year)* _____

Card Security Code *(CVV)* _____ Credit Card Billing Zip Code _____

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

I (patient/authorized representative) grant AxioBionics, LLC authorization to automatically bill the credit card listed above as specified. Notify me via email when my credit card is charged.

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