Disc Disease Solutions, Inc.
100 COMMERCE WAY, SUITE #5 HACKENSACK, NJ 07601 *Tel 888-495-7440 * Fax (201) 880-7799

Credit Card Authorization Form

PLEASE COMPLETE THE INFORMATION BELOW AND RETURN TO US

Cardholder Name:(PLEASE PRNT) _____

Billing Address: _____

_____

_____

Credit Card Type: ☐ VISA ☐ AMEX ☐ DISCOVER ☐ MASTERCARD

Credit Card Number: _____
Expiration Date: _____
Card Security Code: (LAST 3 DIGITS LOCATED ON BACK OF CARD)(FOR AMEX: 4 DIGIT CODE ON FRONT OF CARD) _____

I,(Print Name)_____, authorize the use of the listed credit card, by Disc Disease Solutions, Inc., for the specified transaction and products purchased. This shall include all applicable sales and freight charges herein.

Signature:_____ Date:_____

NOTE: IF YOU WISH TO KEEP YOUR CARD INFORMATION ON FILE WITH US, FOR PAYMENT ON FUTURE ORDERS, PLEASE INDICATE YOUR CHOICE BELOW WITH AN AUTHORIZED SIGNATURE.

Yes _____ No_____ Signature: _____

DISC DISEASE SOLUTIONS, INC. REQUIRES INITIAL PURCHASES ARE PROCESSED VIA CREDIT CARD.
DISC DISEASE SOLUTIONS, INC. ALSO RESERVES THE RIGHT TO CHARGE OVERDUE BALANCES T0 YOUR AUTHORIZED CREDIT CARDS.

ONCE SIGNED PLEASE RETURN TO US:

VIA FAX: 201-880-7799
VIA EMAIL: ORDERS@DISCDISEASESOLUTIONS. COM
VIA USPS MAIL: DDS, INC. 100 COMMERCE WAY SUITE #5 HACKENSACK, NJ 07601