FORENSIC
DRUG TESTING SERVICES, INC

** This submission replaces all previous submissons*

**E-Mail BILLING UPDATE REQUEST**
**Auto-Pay Election**

Clear

# BILLING UPDATE REQUEST

☐ **PLEASE MAIL A HARD COPY OF ALL OUR INVOICES** *($19.00 manual processing fee applies for each mailing)*

**Company's Legal Name:**

**DBA** *(if any):*

**Billing Address**
*(City, State & ZIP):*

**Billing Clerk's Name(A/P):**

**Billing Clerk's E-Mail:**

**Direct Phone:** **Direct Fax:**

**E-Mail for BAT Results & No Show/Refusals:**

**E-Mail for Completed CCF Collections:**

**** Agreed upon payment terms is NET 30, with $49 Late fee applied after 30 days of Invoice ****

***Submitter's PRINTED Name:*** ***Submitter's Signature*** ***Date***

PayPal MasterCard VISA AMERICAN EXPRESS

# AUTO-PAY ENROLLMENT

☐ **YES,** *Please*
☐ **NO,** *Thank you.*

**Name Printed on Card:** **Expires:**

**Card Number:** **CVV:**

**Billing Address:** **ZIP:**

*I understand that this authorization will remain in full effect until I cancel it in writing, and I agree to notify FORENSIC DTS, Inc. in witting of any changes in my account information or termination of this agreement at least 15 days prior to the next billing date. If the billing/payment dates fail on a weekend or holiday, I understand that the payments may be executed on the next business day, or when my account becomes 45 or more days past due. I acknowledge that the origination of Credit Card transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of the above list Credit Card and will not dispute these scheduled transactions; so long as the transactions correspond to the terms indicated within this authorization form. It is understood that auto-payment(charges) will occur no less than once a month, for charges incurred.*

***Submitter's PRINTED Name:*** ***Submitter's Signature*** ***Date***

**Please e-mail completed form to:** *info@fdtsi.com*....**Thank you**

11/18/2021