

BILLING UPDATE REQUEST

PLEASE SEND HARD COPY OF INVOICE (*\$19.00 manual processing fee*)

E-Mail is OK

Companies 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:

Company President/CEO/Owner's Name:

Company President/CEO/Owner's E-Mail:

Cell:

** Agreed upon payment terms is NET 15, with \$49 Late fee applied after 30 days of Invoice **

Submitter's PRINTED Name:

Submitter's Signature

Date



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 writing 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 fall 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