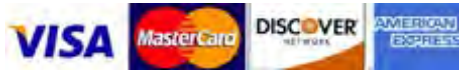




**AUTO-PAY  
Enrollment Form**

I attest that I am the authorized card/account holder of the below listed credit/debt/checking account, shown below and I am duly authorized to make regular debts/charges/withdraws from said account. As such, I am authorizing Forensic Drug Testing Services, Inc. to use the below account information to set-up regular auto-payment for my past, current and future open Invoices. This auto-pay authorization shall remain valid, until canceled by either parties written directives.

**OPTION 1:**



**CREDIT/DEBT CARD AUTO-PAY**

**COMPANY NAME:**

**Date:**

**Authorized Card/Account  
Holder's Name:**

**Card Number:**

**Exp Date:**

**Security Code:**

**Billing ZIP:**

**Card's Billing Address:**

**City:**

**State:**

**Phone:**

**OPTION 2:**



**CHECKING ACCOUNT AUTO-DEBT (E-Check):**

**Business or Personal Checking Account?:**

**Checking Account Number:**

**Routing Number:**

**Bank Name:**

**Branch Phone:**

**Account Holder Authorization & Agreement for Forensic DTS, Inc to process auto-payments from the above account.**

***Authorized Signature:***

**Name Printed on Card/Account:**

**PRINTED Name of Person submitting this form:**

**Submitters E-Mail for Confirmation:**