**INR-F-004**

# INR Pro© Auto-Debit Recurring Billing Authorization Form

## Customer Information

Name _____

Address _____

_____

City _____

State _____ Zip _____

Email _____

**Healthcare System Solutions**
PO Box 1027
Iowa City, IA 52244-1027

Developers of INR PRO

Please select one payment option below

| ☐ **Bank Account Information** | ☐ **Credit Card Information** |
|---|---|
| ☐Checking ☐Savings | ☐MasterCard ☐Visa ☐American Express ☐Discover |
| _____ Bank Name | _____ Name on Credit Card |
| Bank Routing Number | Credit Card Number |
| _____ Bank Account Number | _____ Expiration Date (mm/yy) _____ CCV # |

Number of Systems = ____

Total Monthly Payment Amount = _____

Should the number of active patients exceed the listed quantity for any INR Pro© system, I authorize Healthcare System Solutions to automatically increase the monthly payment amount as described on the INR Pro website, www.inrpro.com. Changes and/or cancellations to this agreement must be sent to sales@inrpro.com or mailed to their address on this form.

I agree that if I have any problems or questions regarding INR Pro service, I will contact Healthcare System Solutions for assistance, using the contact information located on their web site at www.inrpro.com or www.healthcaresystemsolutions.com.

I authorize Healthcare System Solutions, and their payment gateway, to run an address verification search. This verification process is a security measure to protect me, the client, from illegal fraud against my credit card. I guarantee and warrant that I am the legal cardholder for this credit card, and that I am legally authorized to enter into this recurring billing agreement with Healthcare System Solutions.

Mail this form to the following address, **and** contact us at sales@inrpro.com, so we can get your service started immediately

_____ _____

Authorized Signature Date