RecordMyDocs.com
staff@recordmydocs.com

Credit Card Authorization/Payment Agreement

Method of Payment: ☐ **Check** ☐ **Credit Card**

Check #_____ Amount $_____

Please write checks for an amount that is quoted , or leave checks blank, or include a "not to exceed" amount in the memo area of your check. Payment must be made in full prior to services being performed.
Please take a color picture of the front and back of the check and email our office.
Document transfer taxes may be collected in advance.
Please make checks payable to Record My Docs

Credit Card Type: ☐ Visa ☐ Mastercard ☐ Amex ☐ Discover

Credit Card #_____

Expiration Date:_____Security Code:_____

Billing Address:_____City:_____

State_____ Zip_____ Phone: _____

I authorize the purchase of services from ASCC, Inc. using this Credit Card Authorization Form. By using this account for payment a convenience fee of 3.5% of the total amount charged will be added to my invoice.
I agree that I will pay for any purchase and indemnify and hold ASCC, Inc. harmless against any liability pursuant to this authorization.
I understand that my signature on this form serves as authorized signature on the credit card charge slip.

Cardholder Signature:_____ Date:_____

Cardholder Name:_____