KCK medical
Offering great value, high quality products

NEW RESIDENT ACCOUNT SET-UP

Email to: accounting@kckind.com

Customer Service: 888-880-1967

RESIDENT INFORMATION

Resident Name: _____ Phone #: _____

Address: _____ Email: _____

City: _____ State: _____ Zip: _____ Pricing: *Retail* *Contract*

FACILITY INFORMATION

Facility Name: _____ Phone #: _____

Address: _____ Email: _____

City: _____ State: _____ Zip: _____ Contact: _____

PAYOR INFORMATION

Card Holder Name: _____

Billing Address: _____ Phone #: _____

City: _____ State: _____ Zip: _____ Email: _____

Visa *Mastercard* *AmEx* *Discover*

Card Number: _____ Exp. Date: _____ 3 Digit Security Code: _____

I authorize KCK Industries, Inc. to charge my credit card the amount of each invoice when the order is fulfilled. I certify that I am an authorized user of this credit card and will not dispute these scheduled transactions with my bank or credit card company; so long as the transactions correspond to the terms indicated in this authorization form. I am responsible for informing KCK Industries, Inc. of any changes in the above information. I will ensure that charges will not exceed any established credit limits or available balances on the date of transactions.

I agree to the above terms and conditions.

Signature: _____ Date: _____

Would you like your receipts printed or emailed? Printed Emailed

Email: _____

PLEASE DO NOT WRITE BELOW. FOR INTERNAL OFFICE USE.

Customer No.: _____ Processed On: _____ Processed By: _____