ARKLIGN LABORATORIES

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EasyPay Automatic Payment Agreement

Laboratory Name: _____

Cardholder Name (As it appears on card): _____

Billing Address (Street, Suite No.): _____

(City, State, Zip): _____

Billing Phone: _____ Card Number: _____ Expiration Date: _____

Card Type: ☐ Visa ☐ Mastercard ☐ American Express ☐ Discover

Verification Code (4-digit number on the front of Amex or 3-digit number on the back of other cards): _____

I HEREBY AUTHORIZE ARKLIGN LABORATORIES TO CHARGE MY CREDIT CARD LISTED ABOVE TO PAY MY ARKLIGN LABORATORIES BILLS. I UNDERSTAND THAT AUTOMATIC PAYMENTS ARE REQUIRED IN ORDER TO MAINTAIN AN ACCOUNT WITH ARKLIGN LABORATORIES.

Cardholder/Authorization Signature (Emailed or faxed signature will serve as original): _____ Date: _____