

Credit Application

General Information:

Business Name _____	Credit Terms Requested	<input type="checkbox"/> Net 15	<input type="checkbox"/> Net 30	
DBA _____	Credit Limit Requested	\$ _____		
Address _____	Business Website	_____		
_____	Business Phone	_____		
_____	Business Fax	_____		
Billing Address _____	Tax ID (or SS#)	_____		
_____	A/P Contact	_____		
#Yrs in Bus. _____	Phone/Email:	_____		

Corporation
 Partnership
 Sole Proprietor
 S-Corporation
 LLC or LLP
 Other

Names of Owners, Partners, or Officers:

Bank Reference:

Bank Name _____	Branch _____
Address _____	Phone _____
_____	Fax _____
Loan Officer _____	Credit Line _____
<input type="checkbox"/> Checking Acct _____	<input type="checkbox"/> Loan Acct No _____

Trade References:

Name _____	Name _____
Address _____	Address _____
_____	_____
_____	_____
Phone _____	Phone _____
Fax _____	Fax _____
Account No _____	Account No _____

Purchase Orders: Fax to [678-680-5818](tel:678-680-5818) or Email to customerservice@protherapysupplies.com
Authorization:

Pro Therapy Supplies is hereby authorized to obtain any information necessary to establish credit worthiness from any source listed on this credit application and we release any source from all liability for such information provided. The information provided will be used solely for the purpose of establishing credit for purchasing products from Pro Therapy Supplies.

 Printed Name of Applicant

 Title

 Signature

 Date

Pro Therapy Supplies, LLC Credit Card on File Authorization Form

Pro Therapy Supplies, LLC will be stated as Pro Therapy Supplies or "PTS" throughout this document.

I, _____ hereby authorize PTS to keep my credit card number on file and to use that number to pay any fees associated with my product orders.

This is to verify that I, _____ authorize PTS to pay my account with the use of my MasterCard, Visa, Discover or American Express credit card.

By this credit card document I hereby give my complete approval to pay in full for all specific products and/or services which I have directly ordered and authorized to be purchased from PTS. PTS will only charge my card, for orders placed upon my authorization.

I understand that the charge reflected on my credit card statement will be in the name of Pro Therapy Supplies LLC and/or PTS. My authorized signature on this form will be valid for "ANY FUTURE, ON-GOING, PRODUCT PURCHASES INCLUDING BUT NOT LIMITED TO ADDITIONAL BILLING."

Today's Date: _____ Name (as printed on card): _____

Company Name: _____

Address: _____

City: _____ State/Zip: _____

Phone Number: _____ Fax Number: _____

Bank Name (on card): _____

Type of Credit Card: Amex Visa Discover MasterCard

Credit Card #: _____ / _____ / _____ Exp date: _____ / _____

CVC Code: _____ (Amex is 4 numbers on front right side of card, Other cards is 3 numbers on back right side of card):

Authorized Signature: _____

Other person(s) authorized to place charges on this card for you and/or your company (print names): _____

By signing above, I acknowledge the above authorization and treat this fax as a copy of my signature on file. I agree to abide by the terms and conditions set forth by PTS policy statement and the issuing credit card company. Furthermore, I understand and agree that the charges specified above are irrevocable and may not be charged back at any time in the future and that all sales are final.

To complete this authorization, please fax a photocopy of the card holder's valid driver license or official picture identification (passport, military id, etc) and the front and back of the signed credit card (please enlarge and lighten copies to make viewable over fax). Print and fax the completed form and the photocopies described to 678-680-5818 or mail completed form and photocopies to Pro Therapy Supplies, 1750 Breckinridge Pkwy, Suite 200, Duluth, GA 30096. Photocopies and signature **are required to process** your order. This is for your protection as well as ours. All transactions are subject to approval. Your order cannot be processed until this signed document is on file. This credit card policy aims to protect you, our valued customer, from any fraudulent use of your card by persons other than an authorized card holder. This process helps us ensure that all our customers are fully informed and protected. If you no longer desire your credit card information to be retained on file, please call us and we will immediately destroy this form. We may also, at our discretion, review all such forms on file and destroy those that have not been used for an extended period of time. Should we deem this necessary, you may be required to submit a new authorization form in the future. We thank you very much for your cooperation and good will.