BioCorRx Recovery Program

New Provider Accounts Payable Form

Provider Information			
Clinic Name:		**Date:**	
Address:			
Phone:			
Doctor Name:			
Office Contact:		**Phone:**	
Billing Contact:		**Phone:**	

Payment Authorization Form

Here's How Authorized Payments Work:

You authorize charges to your checking/savings account or credit card as per your agreement.
You will be charged the amount indicated in your contract for each order placed. A charge will appear on your bank statement as an "ACH Debit." You agree that no prior-notification will be provided unless the date or amount changes, in which case you will receive notice from us at least 24 hours prior to the payment being collected.

Please Complete the Information Below:

I_____authorize BioCorRx Inc. to charge my credit card
(full name)

or process an ACH debit to my account indicated below for each order of the BioCorRx Recovery Program as specified in my Supply and Distribution Agreement or Fee Schedule.

Billing Address_____ **Phone#**_____

City, State, Zip _____ **Email** _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify BioCorRx Inc. in writing of any changes in my account information or termination of this authorization at least 24 hours prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. For ACH debits to my checking/savings account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Non-Sufficient Funds (NSF) or the decline of the credit card, I understand that BioCorRx Inc. may at its discretion attempt to process the charge again within 5 days, and agree to an additional $25.00 charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card/bank account 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.

Checking / Savings Account Authorization	
☐ Checking	☐ Savings
Name on Acct	
Bank Name	
Account Number	
Bank Routing #	
Bank City/State	

INCLUDE A VOIDED CHECK

Credit Card Authorization	
☐ Visa	☐ MasterCard
☐ Amex	☐ Discover
Cardholder Name	
Account Number	
Exp. Date	
CVV (3 digit Number on back of card MC/VISA) / (4 digit Number on front of AMEX)	

Authorization Signature	
Authorized Signature	
Authorized Date	

Please Fax or Email Completed Form to BioCorRx Inc. Fax: 657-210-4683 or lf@biocorrx.com
All material must be received upon execution of agreement(s).