Payment Authorization Form

CARDHOLDER INFORMATION

Full Name:

Company/Clinic Name:

Billing Address:

City, State, ZIP:

CREDIT CARD INFORMATION

Credit Card Type: ☐ Visa ☐ MasterCard ☐ AmEx ☐ Other

Card Number:

Expiration Date: / CVV:

APC

AUTHORIZATION

By signing below, I, the undersigned Cardholder, hereby authorize A Peptide Company (the "Company") to charge the credit card identified on this form for charges I have authorized and/or for amounts invoiced for products and/or services rendered by the Company in accordance with the terms agreed between me and the Company (including recurring charges, subscriptions, and any authorized late fees).

I authorize the Company to store the card information securely and to use a payment token or other secure method for future transactions. I represent and warrant that I am an authorized user of the card and that I will not dispute the payment with my bank so long as the transaction corresponds to the terms described in this authorization.

I understand and agree that the Company may charge the card for: (a) the amount(s) and frequency set forth in the separate service agreement or invoice; (b) any additional amounts I have authorized in writing; and (c) reasonable fees and costs incurred by the Company for returned payments, chargebacks, or collection efforts. I agree to promptly notify the Company in writing of any change in the status of the card (e.g., lost, stolen, canceled) or of any other relevant billing information.

I understand that I may revoke or cancel this authorization at any time by providing written notice to the Company. Revocation or cancellation will not affect charges already processed or authorized prior to receipt of written notice. If I request changes to payment method, billing schedule, or stored card details, I understand a new signed authorization form may be required to effect those changes. A photocopy or electronic image of this authorization shall be valid as the original.

Signature _____ Date _____