AMAC

AMERICAN MEDICAL

APPLIANCE COMPANY

New Client Form

Name of Doctor: _____

Name of Practice: _____

Phone: _____

Email: _____

Shipping Address: _____

_____

City: _____ State: _____ Zip Code: _____

Billing Address (if different from above): _____

_____

City: _____ State: _____ Zip Code: _____

If you would like to keep a credit card on file, please fill out the information below:

Type of Card: AMEX DISCOVER MASTERCARD VISA

Credit Card# | | | | | | | | | | | | | | | |

Exp.date: | | | | | ***this card will be charged unless a check is sent with case**

Cardholder name: _____ Signature: _____

Choose an option below

Charge Card on file when case is shipped ☐ **OR** **Charged on the 1st of the month after issuing monthly statement** ☐

By signing above, I hereby release and authorize the use of the above card to American Medical Appliance Company (AMAC).

***We may use the personal information only to provide you with the services and products.**
***We do not share the personal information unless it's necessary to provide you with the services and products.**

Please email or mail this completed form to AMAC. We look forward to doing business with you.

TheAmericanMac.com | 2308 McDonald Ave. Brooklyn, NY 11223| Phone: 786-305-3622 | AmericanMac305@gmail.com