



By FAX 888-437-9367
By Mail Sunbaked Software Inc.
 9739 - 83 Avenue NW
 Edmonton, AB T6E 2B6
 855-509-1111

ChiroSUITE Credit Card & Electronic Fund Transfer (EFT) Authorization

Completion of this form is required to setup or update Credit Card or EFT information for continuous monthly payments. You can fax back the completed form using the toll-free fax number above or are welcome to scan & email the form to support@chirosuite.ca. Please just always be aware of security concerns when emailing sensitive information.

1. Clinic Information

Clinic Name	Clinic Phone Number
Clinic Address (Street, City, Province, Postal Code)	

2. Credit Card Authorization Information (leave blank if setting up for EFT Authorization below) Note: Visa and Mastercard only

Name on Card	Credit Card Number	Expiry Date (mm /yyyy)
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(or) 3. EFT Authorization Information & VOID Cheque (leave blank if you setup for Credit Card Authorization above)

Financial Institution & Address		Account Type (circle one)		
		Chequing	Savings	Other
Bank Code (123)	Branch Transit Number (12345)	Account Number (1234-1234567)		

For EFT Authorizations, I authorize TD Canada Trust to make monthly withdrawals for the amount specified, by electronic transfer from the designated financial institution and account identified above, on behalf of Sunbaked Software Inc. For Credit Card Authorizations, I authorize Sunbaked Software Inc. to charge my credit card designated above monthly for the amount specified.

Payment is for all ChiroSUITE related fees (licensing/support/backup/etc). Monthly payments will be taken on the 20th of each month for the following month & will not be refunded once processed. If the monthly payment date is a statutory holiday or weekend, the withdrawal will take place on the next business day.

It is my responsibility to complete a new form if I change financial institutions or account numbers. If I am changing Financial Institutions or closing my account, I will not close my old account until payments have been successfully withdrawn from the new account. I understand any change to my payment information must be made a minimum of 5 days prior to the due date, by contacting Sunbaked Software Inc. by mail, email or fax.

	I understand that payments are processed on the 20 th of each month and that any missed payments, any payments rejected due to lost/stolen/compromised credit card, or payments returned for non-sufficient funds (NSF) will be subject to a \$25 NSF fee. Everyone is given 1 free pass on this, my rate to discuss an NSF charge after that is \$225/hr.
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If multiple account holders are required to authorize a withdrawal of funds, then all must sign this authorization form.

Clinic Owner Printed Name	Clinic Owner Signature	Date
Printed Name of Joint Account Holder	Joint Account Holder Signature (if applicable)	Date