Credit Card Authorization. Complete and fax back to 1-813-749-1900 or email back to info@cosmeticdevices.com

Card Holders Information

Name: ____

Mailing Address: ____

City: ____________________ State/Province: __________ Zip/Postal Code: __________

Country: ____

Day Telephone: ( ) ___________________ Email: ______________________________

Payment

☐ Check made payable to Cosmetic Devices LLC

(U.S. Funds only, drawn from a U.S. Bank)

☐

Visa/ MasterCard/ Discover

(American Express not accepted)

Item: __________________

Total Cost: _____________

Card Number: _________________________________

Expiration Date: ______________________________

Billing Zip Code:___________

Signature: ______________________________________ Date: _____________________

No exchanges outside of warranty

1 year warranty is provided

Refunds are not made at anytime.

I authorize Cosmetic Devices to process the above credit card for the amount(s) stated above. Authorized signature is guaranteeing payment on this contract. I understand and agree to relinquish all rights to dispute these charges.