



CREDIT CARD PAYMENT AUTHORIZATION FORM FOR PAYMENT

*Please email the completed form to:
hollandm@brxray.com or kbrock@brxray.com*

Facility Name: _____

Cardholder Name: _____ Cardholder Phone #: (_____) _____ - _____

Cardholder Address: _____

VISA

MASTERCARD

AMEX

Card Number: _____

Expiration Date: ____/____/____ V-Code: _____ (3 digit security code on back of Visa/Mastercard. 4 digit security code on the front of American Express.)

- Check One: Make this my automatic payment method on all invoicing.
 Keep this information on file that I may pay this way occasionally.
 Use this payment method for this service call only.

Email (Person authorizing this payment method): _____

Signature: _____ Date: ____/____/____

Accounts Payable Name: _____ Accounts Payable #: (_____) _____ - _____

Accounts Payable Address: _____

***** 3% PROCESSING FEE MAY BE APPLIED*****

SERVICE TICKET REQUEST

***** AVOID PROVIDING CONTACT NUMBERS THAT DIRECT TO AN AUTOMATED SYSTEM*****

Contact Name: _____ Direct Phone #: (_____) _____ - _____

Service Address: _____

Description of Issue: _____

REMOTE SERVICE PRICING

Digital Medical: \$410/hour
After Business Hours: Time & ½
½ Hour Minimum Charge

Podiatry, Veterinary & Chiropractic:
\$185/hour + Travel

New Non-Medical Customer: \$250/hour

ON SITE SERVICE PRICING

Radiological Medical: \$310/hour + Travel
CT Service: \$475/hour + Travel
PM: \$450/hour + Travel

Podiatry, Veterinary & Chiropractic:
\$185/hour + Travel

New Non-Medical Customer: \$250/hour