phone: 845-331-7400
fax: 845-335-4105
email: customerservice@recoursa.com
web: www.recoursa.com
address: PO Box 448, Accord, NY 12404

Credit Card Payment Authorization Form

Client ID:

Client Firm Name:

Client Contact Name:

Please complete the information below:

Recoursa Information Solutions, Inc. is authorized to charge the credit/debit card indicated below for services requested by me/my firm, pursuant to Recoursa Information Solutions, Inc. payment terms.

Billing Address: ______________________________

City, State, Zip: ______________________________

Phone: __________________________

Email: __________________________

Account Type: ☐ Visa ☐ MasterCard ☐ AMEX ☐ Discover

Cardholder: ____

Card Number: ____

Expiration Date: ___________

Security Code: ___________

SIGNATURE ___________________________________ DATE __________________

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. I understand that by doing so, I also agree to attempt resolution of any perceived non-performance on Recoursa Information Solutions Inc.'s part with no less than 5 business days' ***written*** notice prior to initiating a dispute with the issuing bank. Failure to provide such notice may cause future services requested by client to be paid in advance by certified bank check.

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