



CREDIT CARD AUTHORIZATION

Payment Authorization Confirmation

This document authorizes KlinIQ to process payment for the marketing system being implemented for the clinic listed below. This authorization allows KlinIQ to charge the agreed setup fee and monthly service fee so the marketing infrastructure and AI appointment systems can be built and managed for the clinic.

Clinic Information

Clinic or Group Name:

Clinic Location:

Primary Contact Name:

Email Address:

Phone Number:

Date:

Cardholder Information

Secure Information — All cardholder data is treated as strictly confidential and used solely for payment processing related to KlinIQ services.

Cardholder Name:

Credit Card Number:

Expiration Date:

CVV:

Billing Zip Code:

Billing Address: _____

Payment Authorization

Setup Fee Authorization

I authorize KlinIQ to charge the one-time setup fee for the marketing system being implemented for my clinic.

Authorized Setup Fee Amount: \$ _____

Monthly Service Authorization

I authorize KlinIQ to charge the monthly service fee for the marketing system and services provided to my clinic.

Authorized Monthly Amount: \$ _____

Agreement

Both parties confirm that the payment authorization above accurately reflects the agreed setup fee and monthly services associated with the KlinIQ marketing system being implemented.

KlinIQ

Name: Pretish Patel

Title: CEO

Company: www.KlinIQ.tech

Authorized Cardholder

Name: _____

Title: _____

Clinic: _____

Signature: _____

Date: _____

Confidentiality Notice: This authorization form is used solely for payment processing related to KlinIQ services. All information submitted is treated as strictly confidential, securely protected, and will never be shared, sold, or distributed to any third party.



KlinIQ LLC — MedSpa Marketing Agency