Credit Application

Business Name: _____

Contact person: _____

Email address: _____

Phone: (_____) – (_____) – (_____) **Fax:** (_____) – (_____) – (_____)

Address: _____ | _____ | _____ | _____
(STREET) (CITY) (ST) (ZIP)

OWNERS NAME: _____

Personal/Cell Phone: (_____) – (_____) – (_____)

Address: _____ | _____ | _____ | _____
(STREET) (CITY) (ST) (ZIP)

Bank Information:

Bank Name: _____ **Contact**: _____

Address: _____ | _____ | _____ | _____
(STREET) (CITY) (ST) (ZIP)

Phone: (_____) – (_____) – (_____)

IF YOUR COMPANY IS TAX EXEMPT, YOU MUST ATTACH YOUR TAX EXEMPT CERTIFICATE WITH THIS APPLICATION , OR TAXES WILL BE ASSESSED ON EACH INVOICE

TAX EXPEMPT # _____

OPTICAL REFERENCES

Company Name	Address	Telephone #	Acct #
(1)			
(2)			
(3)			

TERMS: **OPTOGENICS** terms for payment are net 25 days. Past due accounts are subject to finance charges of 2 percent per month. In opening your account at **OPTOGENICS** you assume and become totally responsible for all collection costs both personally, corporately and/or under an "assumed name". Your acceptance of special ordered prescription lenses and not paying for them will result in your being charged for all costs incurred by **OPTOGENICS of SYRACUSE** their attorneys, accountants, collection agency fees and any court costs plus interest charges. These charges will be added to the unpaid balance and become the responsibility of the purchaser in full.

PURCHASER: _____ DATE: _____
(please. print name)

signature: _____

PO Box 4894 Syracuse NY 13221 T: 1-800-OPTICAL (678-4225)

PAY BY CREDIT CARD (FAX BACK TO 315-445-8994)

Payment Terms:

☐ I authorize Optogenics to charge my credit card automatically every month, in the amount of my entire statement amount, on the (circle one) 1st 15th 28th of each month.

☐ I authorize Optogenics to charge my credit card after my review of the statement and I phone in the dollar amount I would like to charge.

☐ I authorize Optogenics to charge my credit card on a pre-pay basis in the amount of $_____ every time my balance with Optogenics is less then $_____.

☐ I authorize Optogenics to charge my credit card ONLY in the amount specified on this form.

Optogenics Account Information:

Account Number:_____ Account Name:_____ __Date:_____/_____/_____

Credit Card Information:

TYPE: VISA / MASTER / DISCOVER / AMEX

Card Number:_____-_____- _____-_____ Exp:___/____
Sec Code:_____ (3 digits in the back of your card)
Name as it APPEARS on the card:_____

Billing Address for the card:_____

_____ _____
(AUTHORIZED SIGNATURE) **(PAYMENT AMOUNT)**