CHEMOCOLDCAPS™

Payment Authorization Form/Rental Agreement

Patient name: _____

_____ Initial I hereby authorize Chemotherapy Cold Caps, LLC (CCC) to charge the credit card listed below in the amount of $425 for each month's rental on or about the same day as the original charge.

_____ Initial I will be charged a **non-refundable AMOUNT OF $500.00 when the equipment ships. This includes the first month rent of $425 and $75 for shipping.** Local pick-ups charged $425.

_____ Initial I understand monthly charges will continue until the equipment is returned.

_____ Initial I understand that if I fail to pack and return the caps and equipment according to provided return ship instructions, I will incur a $500.00 charge.

_____ Initial I agree to have CCC charge future monthly payments to this same credit card.

_____ Initial My Doctor and or treatment facility are aware and ok with my use of cold caps.

Signature: _____ Date: _____

Email: _____

Card number: _____ - _____ - _____ - _____

Name on Card: _____

EXPIRATION: _____/_____ CVV (Security Code) _____

ADMIN ONLY
