

KINEMEDIC CONCEPTS, INC.



Please mail or Fax completed Credit Card order form to:

P.O. Box 3220 Blue Jay, CA 92317 - Fax (909) 498-0300 - Phone: (909) 337-3449

Estimate or Invoice #: _____

Name on Card: _____

Billing Address for Card: _____

Type of card, (circle): Visa MasterCard American Express Discover

Amount to be billed to credit card (amount of estimate or invoice) _____

Credit Card # _____ Security # on back _____

Security # on front if AMEX _____ Expiration Date: _____

Signature: _____