Health Solutions

Customer Information Sheet

By completing this form you authorize the bank and trade references given by you to release such information as may be necessary to establish an account. It is understood that this information will be held in strictest confidence by Health Solutions LLC.

PLEASE PRINT YOUR INFORMATION IN THE BLANKS PROVIDED

Business **Legal** Name (*Your name if proprietorship*) _____

Name **doing business as** (*if different than above*) _____

Form of Business Organization (*check only one*) ___ Corporation ___LLC ___Partnership ___Proprietorship

Mailing and Billing Address _____ Suite /Apt#_____

City _____ State _____ Zip _____

Shipping Address_____ Suite/Apt# _____

City_____State _____ Zip _____

Business Phone (_____) _____-_____ Fax Phone (_____) _____-_____ Other (_____) _____-_____

Business Owner's Name_____

PO required? Yes___ No___ Accounts Payable Contact Name and Email Address_____

Email Address_____

Check one Prepaid_____ Terms_____

Do require retail packaging_____

*** *We Accept All Major Credit or Debit Cards** Type of Card: Visa, Mastercard, American Express**

Card#_____, Exp. Date_____ CVC/CSC#_____

Billing address_____

PAYPAL_____

or

For 15 or 30 Day Credit Terms Please complete below:

Bank (Checking Account) Reference

Name_____

Address_____

City/State_____

Phone_____ Acct#_____

Authorized Signature_____ Title_____ Date_____

Mail application to: Health Solutions POB 3126 Ocala, Fl 34478
Fax application to: 1-352-291-2309
Questions: 1-352-237-9328
email support@fittherapy.com