

LVE CREDIT APPLICATION

Please complete the Credit Application and fax or mail back to establish a line of credit with Las Vegas Esthetics, Inc.

We affirm that the forgoing information contained in this application is presented for the purposes of establishing credit and is true, complete and accurate. Las Vegas Esthetics, Inc is authorized to make any investigation of my credit or employment status whether directly or indirectly through an agency employed by Las Vegas Esthetics, Inc for that purpose. You may also disclose to any interested parties or agencies your experience with this account. We agree to inform Las Vegas Esthetics, Inc immediately of any matters that will cause significant change in my financial condition on existing or new orders. If this application is accepted by Las Vegas Esthetics, Inc, we agree to the following terms:

Las Vegas Esthetics, Inc. payment policy is as follows:

Full payment of monthly statement is due by the fifteenth of the following month. A service charge of 1.5 % will be incurred if full payment of prior month's statement is not received by the last business day of the following month.

Payment Option: You may opt to authorize auto run of a credit card. With documented authorization, credit cards are run on the first of each month for the full amount of the monthly statement. If you should choose this payment option, please complete the attached authorization form and fax back with completed credit application. For your convenience, we accept: Visa, MasterCard, American Express and Discover.

*Any case that has to go over 60 days overdue will be sent on a COD basis. Status of extended credit will resume once account is paid in full.

Credit References:

- | | |
|-----------------------|-----------------------|
| 1. Name: _____ | 2. Name: _____ |
| Account Number: _____ | Account Number: _____ |
| Phone Number: _____ | Phone Number: _____ |
| Address: _____ | Address: _____ |
| _____ | _____ |
| _____ | _____ |

I, _____ understand and agree with Las Vegas Esthetics Inc.'s terms of policies of payment and I will make payments according to these terms and policies.

Dental Practice License Number: _____

Signature: _____ Date: _____