DIRECT PAYMENT AUTHORIZATION FORM

I, _____, an authorized representative of _____ ("ORGANIZATION"), authorize Skyscape Medpresso, Inc. ("COMPANY") to debit/charge **Organization's account** via the payment method as outlined below:

☐ ACH (Bank Transfer)

☐ Checking Account ☐ Savings Account

Bank Name: _____

Routing Number: _____

Account Number: _____

☐ Credit Card Payment[†]

☐ Visa ☐ MasterCard ☐ Amex ☐ Discover

Card Number: _____ Expiration: _____ CVV: _____

Name on Card: _____

Billing Address: _____

PAYMENT TERMS

Payment will be initiated[‡] for the amount/frequency (Monthly/Quarterly/Annually) indicated on the invoice as per the pricing terms agreed in the Platform License signed:

☐ Monthly ☐ Quarterly ☐ Annually

TERMS & CONDITIONS

This authorization remains effective until written notice of termination or account change is provided by ORGANIZATION, giving COMPANY sufficient time to process the request. Please provide a new authorization form in case of any changes to the bank or card details.

[†] Note: Credit card payments will incur a 3% transaction fee

[‡] Payment will be debited/charged within 5 days of the invoice due date

Any changes to the account information should be emailed to **ap@skyscape.com**.

AUTHORIZED SIGNATURE

I agree to the terms above:

Signature: _____ Date: _____

Authorized Officer/Personnel Name (Please Print): _____