P.O. BOX 543
ACWORTH, GA 30101
Phone #: (404) 202-1517 ext. 5010 Fax #: (678) 324-4904
E-mail: angie@twistedtechnologies.com

Support Authorization

Please Fill out online then print, sign, and fax

Company: _____ Address: _____ _____ City, State ZIP: _____ ATTN: _____	Contact: _____ Position: _____ Email: _____
Phone: _____	Fax: _____
Backline Number: _____	

Description of Service Requested

Support Phone Call (1/2 hour minimum $50 – each additional ¼ hour $25)
Technical Support 1 Hour minimum $125/hour

___ Medisoft Version # ___.___.___.___ ___ Net Pro ___ Advanced ___Basic
___ Electronic Claims ___ Gateway ___ Capario ___ Relay Health ___ Zirmed ___ MCC ___ Other
___ Medisoft Clinical Version # ___.___.___

Please describe with as much detail as possible the issue relating to this call. Include the error message received and where you were in the program when this issue began.

_____
_____
_____
_____
_____

Estimated Time for Support: _____

Service will not be scheduled if payment information is missing

Method of Payment: __ Visa __ MasterCard __ American Express

Credit Card Number: _____ Exp. Date: _____

Account Holder's Name: _____

I hereby authorize **Twisted Technologies** to charge my credit card listed above for the product and/or service listed. Finance charges will be computed at 1.5% per month. In the event this matter is turned over to a collection agency or attorney for collection then the cost of collection, court costs, all attorney's fees and penalty of 15% of the outstanding balance will be charged.

Signature: _____ Date: _____