08/2021

# Client Data Profile

Please read and complete this form and return to Private Eyes. Incomplete or invalid entries will delay the approval process and may cause rejection of service.

## BUSINESS INFORMATION

**Business Name of User:** _____

Business Type: ☐ Corporation ☐ Partnership ☐ LLP ☐ LLC ☐ Sole Proprietor ☐ Government

**Address:** _____
Street City State Zip

**Primary Contact Name:** _____
First Last Title

**Phone #:** (_____)_____ **Fax #:** (_____)___ **E-mail:**_____

**Billing Contact Name:**_____ **Phone #:** (_____)_____

**Billing E-mail:** _____

Please describe your company's business: _____

1. Please state the specific purpose for which you intend to use the information provided by Private Eyes Screening Group:
   ☐ Employment Purposes ☐ Other (specify)_____
2. How long has your company been in business?:_____ List approx. number of employees: _____
3. Type of building you are in: ☐ Commercial ☐ Industrial ☐ Residential ☐ Other (explain)_____
4. Please identify two principals (owners) of your business if privately owned, or provide the stock symbol and exchange if your business is publicly traded:

| NAME | TITLE | PHONE |
|---|---|---|
| | | |
| | | |

OR, Symbol_____ Exchange _____

## ACCOUNT SET-UP SPECIFICATIONS

**Service Type:** ☐ Background Check ☐ Drug Screening/Physical ☐ Driver Qualification File Maintenance ☐ Applicant Tracking System

**Tax Information:** ☐ Your Federal Tax I.D. Number_____OR SSN_____(if applicable)

**Billing Preference:** ☐ Invoiced - Due Upon Receipt ☐ Autopay Invoice - Credit Card

**Payment Preference:** ☐ Check ☐ Credit Card ☐ ACH ☐ Other

**Disclaimer:** Private Eyes Screening Group will collect bills, outstanding 30 days or more, automatically using the credit card on file.

**User certifies that the "Master Service Agreement (MSA)" has been read and agreed to as written.**

X_____
**User's Authorized Signature** **Title** **Date**

_____
**Private Eyes Screening Group Authorized Signature** **Title** **Date**

**CREDIT CARD AUTHORIZATION FORM**

9080 Double Diamond Pkwy Unit C
Reno, NV 89521
Telephone: 925-927-3333

For any questions regarding billing, please email:
accounting@pebackgroundchecks.com

**PLEASE SELECT TYPE OF PAYMENT (CHECK ONE):**

| RECURRING | ◯ | ONE TIME ONLY | ◯ | KEEP ON FILE | ☐ |
|---|---|---|---|---|---|

I (name)_____authorize Private Eyes Screening Group to process payment for the total monthly balance due on the account listed using the credit card information provided below.

TITLE: _____

DATE: _____

COMPANY NAME: _____

TYPE OF CARD: _____

CARD NUMBER: _____

EXP. DATE: _____

SECURITY CODE: _____

BILLING ZIP CODE: _____

CARDHOLDER NAME: _____

CONTACT EMAIL ADDRESS: _____
*Credit card transaction receipts will be sent to the above email address.*

If Recurring is selected, payments will be processed on the 15th day of the month. If the payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I understand that this authorization will remain in effect until it is canceled in writing. I agree to notify Private Eyes Screening Group immediately of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company provided the transactions correspond to the terms indicated in this authorization form. My initials below indicate I have read and understand these terms.

Initials _____