

Ross Imaging Center 2460 Dixwell Ave. Unit E Hamden, CT 06514 (203)281-6996

Photo Restoration Mail Order Form

First Name:	Last Name:	Date:
Phone Number:	Email Address:	
Order Comments/ Instructions:		

Preserve your oldest memories with our photo restoration services.

When you send your restoration to us we will give you a call with a quote on how much the restoration will cost. Pricing starts as low as \$43.95 and can range all the way up to \$129.95 depending on the complexity of the photograph. We do not fix the original photograph in any way and we return the original back to you in the same condition.

Please describe to us what you would like done during the restoration:

LIMITATION OF LIABILITY: Submitting any tangible or electronic media, image, data, file, card, disc, device, film, print, silde, or negative for any purpose, such as processing, printing, duplication, alteration, enlargement, storage, transmission, or other handling, constitutes an agreement that any loss or damage to it by our company, subsidiary or agents, even though by our negligence or other fault, will only entitle you to replacement (uantifyisize of unexposed photographic film or electronic media, and processing of the replacement media. Except for such replacement, our acceptance of the media, image, data, file, card, disc, device, film, print, sile escinded. As vergress or implicit we verges of une vergence in the verges of the replacement media.

Select return shipping:

Shipping Type		Cost
UPS Ground		\$12.95
UPS 2nd Day		\$24.95
UPS Overnight		\$34.95
USPS Priority Mail		\$8.95
International		\$20.95
	Total	

Payment Information *Your card will not be charged until the quote is agreed upon.

Payment Type					
Credit Card Select card type >>>	Visa MasterCard	American Express	Discover		
Credit Card Number:			Expiration:		
Security Code Number: CVV Number		Billing Postal Code:			
Check to "Ross Imaging Center" "orders wont be sent back till checks clear					
Billing Address					
First Name:		Last Name:			
Address:					
City:	State:	Zipcode:			
6. Return Address (If different than Billing Address)					
First Name:		Last Name:			
Address:					
City:	State:	Zipcode:			
Lab use:					
Quote:			Approved Deny		
Notes:					

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