Credit Card Authorization Form

AUTO-PAY CREDIT CARD AUTHORIZATION: I (we) authorize *Right Dose Pharmacy* to keep my credit card listed below on file for automatic payment of the following Patient Account. Auto-pay will occur within five (5) business days of statement generation (no later than the 10th business day of the month).

Name of Payer (please print) _____

Address of Payer:_____ City, State, Zip_____

Contact Phone #'s:_____

Card Type (Debit/Credit):_____ _ AMEX / VISA / MASTERCARD

Card Number:_____ Expiration Date: _____ CCV: _____

Send me a receipt: YES / NO Email address:_____

Date to begin auto-pay on this credit card: _____

Right Dose Pharmacy Account to be paid by monthly ACH debit:

Customer Name: _____ Account #_____

Customer Address: _____ City, State, Zip_____

Amount to be debited monthly: Variable_____ Date to be debited: prior to the 10th business day

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Authorized Cardholder Signature Date

***This CC Auto-pay authorization will remain in effect until I (we) notify in writing to *Right Dose Pharmacy* to cancel the CC Auto-pay authorization. Required payment needs to be available in the payment account on the agreed payment date. I (we) release *Right Dose Pharmacy* of all liabilities concerning this payment if funds are not available to make the payment and I (we) will be responsible for making my(our) own payment.