Credit Card Authorization Form

Name:	______________________	**Facility Name (if applicable):**	______________
Card Holders Name:	______________________	**Relationship to Resident:**	______________
Billing Address:	______________________ Address	**Contact Number:**	______________
	______________________ City, State, Zip Code	**Alt Contact Number:**	______________
Payment Method:	□ AMEX □ Discover □ MasterCard □ Visa	Expiration Date: CVV (from back of card): Card ID Number:	______________ ______________

Please choose ***one*** of the following:

I_______________________________, authorize Hartzell's Pharmacy Inc. to:

□ Option 1 – I authorize automatic charges to my credit and/or debit card outlined above monthly for payments owed on the monthly statement for the Resident above. I understand that I will continue to receive a monthly statement for my information and review.

□ Option 2 – I authorize $___________ to be automatically charged to my credit and/or debit card on behalf of the Resident outlined above every month on the ___________________ day of the month. I understand that payment in full is still expected in thirty (30) days of the statement date.

□ Option 3 – I authorize a onetime payment of $___________ to be charged to my credit and/or debit card on behalf of the Resident outlined above.

I acknowledge that Hartzell's will be storing my credit card information on a secure server for billing purposes only. I understand that to cancel this arrangement, I will have to contact Hartzell's Pharmacy in writing directly.

Cardholder Signature: ______________________________ **Date:** ____________________

Please contact a representative in our Billing Office with any questions at (610) 264-5471 or (800) 325-6856, option 4

300 American Street, Catasauqua, PA 18032
Phone: (610) 264-5471 / Fax: (610) 264-3048
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