

Credit Card | Checking Account Consent Form

Resident Name: _____ Date: _____

Facility Name: _____ Customer Number: _____

I authorize Guardian Pharmacy of SE FL to charge my credit card/checking account for:

- A ONE-TIME CHARGE OF \$ _____
- RECURRING MONTHLY CHARGES
- UNPAID BALANCES THAT ARE PAST-DUE (FOR FILE ONLY)

CREDIT CARD CONSENT INFORMATION: VISA MC AMEX DSCV

Name on Card (as it appears): _____

Card No: _____

Expiration Date: ____ / ____ CVN/Security Code: _____

Card Billing Address: _____

Cardholder's Phone #: (h) _____ (c) _____

*SIGNATURE OF RESPONSIBLE PARTY: _____

CHECKING ACCOUNT CONSENT INFORMATION:

Account Holder's Name: _____

Account Holder's Address: _____

Account Holder's Phone #: (h) _____ (c) _____

Bank Name/Branch: _____

BANK ROUTING NUMBER: _____

BANK ACCOUNT NUMBER: _____

*SIGNATURE OF RESPONSIBLE PARTY: _____