Guardian Pharmacy of SE FL * 6100 Broken Sound Parkway NW Suite 1 * Boca Raton, FL 33487 * 954-601-2121, Opt. 1 * www.guardianoharmacyflorida.com * Fax: 954-601-2400

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:_____