CREDIT CARD AUTHORIZATION FORM

Senior Health Pharmacy offers the option to store a card on file. This form will serve as authorization to charge the card you place securely on file with us for the purpose of paying balances due on your monthly statment. Credit and debit card information is stored securely, following PCI compliance guidelines.

Facility Name: ____________________

Patient Name: ____________________

Responsible Party: ____________________

Email: ____________________

Credit Card Information	
Credit Card Type:	☐ Visa ☐ Master ☐ Discover ☐ Other ________
Cardholder Name:	____________________
Billing Address:	____________________
	____________________
Credit Card Number:	____________________
Expiration Date:	__________
CVV:	__________
Cardholder ZIP Code:	__________

I ____________________, authorize Senior Health Pharmacy to charge my credit card listed above for the agreed upon purchases. I understand that my information will be saved for future transactions on my prescription account.

____________________ Signature

__________ Date