

# IPPC Pharmacy

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## CREDIT CARD BILLING AUTHORIZATION FORM

If you would enjoy the convenience of automatic billing to your Visa, Master Card, American Express or Discover Card, simply fill out the information below. Upon approval, we will automatically bill your credit card for the amounts due and your total charges will appear on your credit card statement. You may cancel this automatic billing authorization any time by writing us at the above address.

PATIENT NAME: \_\_\_\_\_

PATIENT ACCOUNT NUMBER: \_\_\_\_\_

### CREDIT CARD INFORMATION

VISA     MASTERCARD     AMERICAN EXPRESS     DISCOVER

NAME ON CARD \_\_\_\_\_

BILLING ADDRESS \_\_\_\_\_

CITY, STATE, ZIP \_\_\_\_\_

DAY TIME PHONE NUMBER \_\_\_\_\_

CREDIT CARD NUMBER \_\_\_\_\_

3 Digit Code on Back of Card (CVA#) \_\_\_\_\_

EXPIRATION DATE \_\_\_\_\_

I authorize IPPC Pharmacy to bill my credit card per the instructions below:

Bill my account one time for \$ \_\_\_\_\_

Bill my account each month automatically for the balance due.

Please tell us how long you want us to automatically bill your credit card:

This authorization is valid for one year from the above date.

This authorization is valid until this date \_\_\_\_\_

Your Signature \_\_\_\_\_