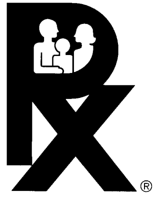

Family Prescription Center

439 Wyandotte Street Bethlehem, PA 18015

Ph: (610) 866-0709 Fax: (610) 861-3877 Email: contact@familyprescription.com

Responsible Party Agreement

Lehigh University Student Information

Name of Patient:__________________________________ **Male/Female DOB** ____/___/___

Named of Person on credit card ____

Credit card billing address ____

City_______________________________**State**_____________**Zip**_____________

Parent Home or Cell Phone ____________________ **Student Cell Phone**________________________

Relationship to Patient_______________________

Payment/Insurance Information

* Attach copy of front and back of insurance card *

I authorize use of this credit card information to be used to charge my son/daughter prescription medication and/or over the counter medications as needed.

____ ______________________

Responsible party/guarantor **Date**

As a recurring transaction, you may charge my Visa MasterCard Discover

Card No.___________________________**Expiration date**______________ **3 Digit Security Code**______

__________________________________ **Date**__________________

(Signature)