



Family Prescription Center

439 Wyandotte Street

Bethlehem, PA 18015

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

Responsible Party Agreement

DeSales 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 _____

(Signature) Date _____

Family Prescription Center...we're taking the time to care.