AUTHORIZATION AGREEMENT FOR AUTOMATIC PAYMENTS

Company Name: GOOD DAY PHARMACY

OPTION #1 (ELECTRONIC FUNDS TRANSFER):

I (We) hereby authorize GOOD DAY PHARMACY, to initiate debit entries to my (our):

□ Checking Account or
□ Savings Account (select one)

indicated below at the depository financial institution named below, and to debit the same to such account. I (we) acknowledge that the origination of EFT (Electronic Funds Transfer) transactions to my (our) account must comply with the provisions of U.S. law.

***PLEASE ATTACH A VOIDED CHECK TO IDENTIFY YOUR BANK INFORMATION BELOW**

ATTACH VOIDED CHECK HERE:

OPTION #2 (RECURRING CARD PAYMENT):

If you prefer to have charges billed to your credit card, please fill in the spaces below. Your card will be billed between the 13th and 20th of each month.

I (We) hereby authorize GOOD DAY PHARMACY, to charge the credit card information provided.

MasterCard / Visa / Discover #: ___ ___ ___ ___ - ___ ___ ___ ___ - ___ ___ ___ ___ - ___ ___ ___ ___

Expiration Date: ___ ___ / ___ ___ (Mo) (Yr) 3 Digit Security Code: ___ ___ ___

Please Complete:

This authorization is to remain in full force and effect until GOOD DAY PHARMACY has received written notification from me (or either of us) of its termination in such time (at least five (5) business days) as to afford GOOD DAY PHARMACY and DEPOSITORY a reasonable opportunity to act on it.

Name(s)_____ (Please Print) Patient Name _____

Date_____ Signature _____

To receive 'Encrypted' statements by email, provide address here: _____