Scribner Drugstore Payment Information

I ________________________________ authorize Scribner Drugstore to
(Name)

store my payment information encrypted at POS and process for copays/charges incurred.

Cardholder Name: ________________________________

Credit Card Number: ______________________________

Card Type: ____________ Exp. Date: ____________

Sec. code: ____________ Billing ZIP: ____________

____
(Signature)

402-664-3133 p
402-664-3074 f