MEDICAL ARTS PHARMACY

2102 Pecos Street San Angelo, TX 76901
Phone: 325.949.4636 Fax: 325.942.0761
Email: map@medicalartspharmacy.net

Automatic Payment Authorization

For your convenience, we offer the following services. Please choose from the options below:

_____ Yes! I would like to have my credit card billed monthly as payment to my account.

_____ Yes! I would like to have my checking account drafted monthly as payment to my account.

Credit Card Information: (Note: This confidential information will be securely maintained.)

Cardholder: _____ Phone #: _____

Card Number: _____

Expiration Date: _____ Security Code: _____

Address: _____

City: _____ State:_____ Zip: _____
*Charged at time of statement.

Checking Account Information: (Note: This confidential information will be securely maintained.)

Name on account: _____

Address: _____

City: _____ State:_____ Zip: _____

Bank Name: _____ City & State: _____

Bank routing #: _____ Bank Account #: _____
*Drafted on the 10th of the month (or first business day after)

As a responsible party, I (we) agree to pay Medical Arts Pharmacy with 30 days of receipt of billing statement. If billed to prescription insurance, statement charges will include co-pays only and medications not covered. I (we) authorize Medical Arts Pharmacy to charge my credit card/bank account for the balance due as stated above. I (we) agree to service charges for emergency services where applicable.

Resident Name: _____

_____ _____

Responsible party signature Date