Automatic Credit/Debit Card Charge Authorization Form

227 Main Street
Fort Fairfield, ME 04742
Phone: 1-888-422-7319 Fax: 1-877-422-7319

By signing this form, I authorize I Care Pharmacy to automatically charge my credit or debit card for the cost of my prescription purchases as specified below. I understand that I will not receive a phone call in advance. I may cancel this automatic charge authorization at any time by providing I Care Pharmacy with a 15 day written notice.

I, ______________________________, hereby authorize I Care Pharmacy to charge my credit/debit card as specified below for co-pays due.

____

Mailing Address (Street or P.O. Box) City State Zip Code

______________________________ ____________ ____________

Card number (Visa/MasterCard/Discover) Exp. Date CVC/CVV*

______________________________ ______________________

Client E-mail Address Telephone number

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Cardholder's Billing Address as shown on credit card statement (if different than above)

______________________________ ______________________________

Name as it appears on Card (please print) Card holder's signature

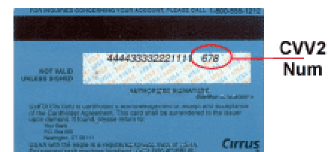
For your convenience, please indicate option below for credit/debit card charge authorization.

☐ Monthly: Automatically charge the monthly statement balance on the 3rd of each month.

☐ Automatically charge for copay amount at the time of each prescription fill.
(If copay amount is under $3.00, your card may not be charged until the beginning of the following month.)

- ***Your credit/debit card information will be kept secure and will only be used for the purpose of payment for your prescription purchases.***
- ***If your automatic charge fails due to insufficient available funds, I Care Pharmacy reserves the right to terminate this agreement and require pre-payment of purchases.***

*3 Digit Security Code (CVC or CVV) is located on the back of your credit card to the right of credit card number.



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