Payment Authorization Form

Patient Name:	
Patient DOB:	
Card Holder Name:	
Card Holder Address:	
Credit Card Number:	
Exp	
CVV	

- I, _____, authorize Hartzell's Pharmacy Inc to charge my credit and/or debit card for the End of Month balance due for the Patient listed above.
- Charges will occur monthly, after month-end closing, between the 1st and 10th of the following month.
- Hartzell's will store the card information on a secure server as a token for billing purposes only.
- I acknowledge that all information provided is complete and accurate.
- To cancel this arrangement, I must contact Hartzell's Pharmacy in writing directly.

Questions should be directed to the Hartzell's Pharmacy billing department at 610-264-5471 ext 401 or hmebilling@hartzells.com.

NAME			
SIGNATURE		DATE	

300 American Street, Catasauqua, PA 18032
Phone: (610) 264-5471 / Fax: (610) 264-3048