OPTIONAL -- CREDIT CARD AUTHORIZATION FORM -- OPTIONAL

Instructions: Please complete this form if you wish to authorize Guardian Pharmacy of Maine to maintain your credit or debit card on file and to bill your card for your supplies and medications.

Patient/ Resident Name (Please Print): _____
Guardian or POA Name (Please Print): _____
(Last, First and Middle Initial)

Mailing Address (Please Print): _____
_____
_____

Phone: (_____)_____

Physical Address (Please Print): _____
☐ (Check if it is the same as mailing address)
_____

I, (print name) _____, hereby authorize the use of my credit or debit card for payment of my prescriptions and/or other purchases.

This authorization is valid until (Date): _____/_____/_____
Month Day Year

Please select card type:
☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

Credit Card #: _____

Expiration Date: _____ 3 Digit Security Code (from back of card) _____

Name as it appears on the credit card: _____

Are you an authorized user of this Credit Card? ☐ YES ☐ NO

Please select one of the following options:
☐ Yes, I would like my Credit Card receipt mailed to me.
☐ No, I do not want my Credit Card receipt mailed to me.

_____ _____/_____/ 20_____
SIGNATURE OF CARDHOLDER Month Day Year

- **Any changes must be submitted in writing to the address below. –**

OFFICE USE ONLY: Account Code: _____ Location: _____
NOTES:

OPTIONAL

3 Business Parkway, Suite 2, Brunswick, ME 04011
Tel: (207)-373-9077 Fax: (207)-373-9088

OPTIONAL