



Prime Pharmacy

Address: **64 Rainier Ave S Unit H
Renton, WA 98057**
Phone: **206-829-4908**
Fax: **206-829-4906**
Email: info@theprimepharmacy.com
Website: theprimepharmacy.com

Credit Card Authorization Form

Card Type:	Visa/MasterCard/AMEX/Discover
Name on Card:	
Billing Address:	
City/State:	
Zip Code:	
Card Number:	
Expiration Date:	
Security Code: (CVV)	
Patient's Name:	
Patient's DOB:	
Name of Assisted Living Facility:	

I _____, authorize Prime Pharmacy to charge automatically to my credit and/or debit card outlined above monthly for payments owed on the monthly statement for the client above. I understand that I will continue to receive a monthly statement for my information and review.

I acknowledge that Prime Pharmacy will be storing my credit card information on a secure server for billing purposes only.

I understand that upon receiving notification of the client above leaving the facility above, Prime Pharmacy will charge any remaining balance on the client's file to close out the account.

I understand that to cancel this arrangement, I will have to contact Prime Pharmacy in writing directly.

Cardholder Signature: _____ Date: _____