1412 SW 43rd Street Ste 120 • Renton, WA 98057
(P) 425-251-6335 • (P) 877-425-MEDS • (F) 425-251-6337
www.ReadyMedsPharmacy.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 Ready Meds Pharmacy, Inc 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 Ready Meds 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, Ready Meds 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 Ready Meds Pharmacy in writing directly.

Cardholder Signature: ________________________________ Date:____________________