1412 SW 43rd St. • Suite 120 • Renton, WA 98057
P 425-251-6335
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- from back of card.)	
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 to cancel this arrangement, I will have to contact Ready Meds Pharmacy in writing directly.

Cardholder Signature: _____ Date: _____

Please contact a representative in our Billing Office with any questions at (425) 251-6335.