Freedom Pharmacy

434 Hurricane Lane, Williston, VT 05495
802-655-3544 or 1-800-638-1675 Fax 802-655-0123
www.freedompharmacyvt.com

Patient's Name: _____ Patient's DOB: _____

OPTION 1
AUTOMATIC ACH PAYMENT AUTHORIZATION

I (we) hereby authorize Pharmacy Direct Delivery, LLC (dba Freedom Pharmacy) to charge my bank account indicated below at the depository financial institution (my bank) named below, and to debit the monthly statement amount during the 1st week of each month.

Bank Name: _____ Type of account: ☐ CHECKING ☐ SAVINGS

Routing Number: _____ Account Number: _____

Signature: _____ Date _____

Printed Name: _____

OPTION 2
AUTOMATIC CREDIT CARD PAYMENT AUTHORIZATION

I (we) hereby authorize Pharmacy Direct Delivery, LLC (dba Freedom Pharmacy) to automatically process my monthly statement charges during the 1st week of each month by way of my credit card (below), until written notification to the contrary is given.

Type of credit card: ☐ MASTERCARD ☐ VISA ☐ AMEX ☐ DISCOVER

Credit Card Number: _____ Exp. Date: _____ Security Code: _____

Name on Credit Card: _____ Email: _____

Credit Card Billing Address: _____

Signature: _____ Date _____

-By completing and executing this form, the cardholder acknowledges and agrees that Pharmacy Direct Delivery, LLC (hereafter "Company") is authorized as of the authorization date set forth above and subject to the terms and conditions set forth below, to charge the credit card, debit card, charge card or other payment card (hereafter "credit card"), specified above for the amounts billed to the account holder or cardholder specified above for services and products provided. -Company will send the account holder or cardholder an invoice for services/products provided upon request. Company will charge the above credit card for the amount specified in the statement on the date of the statement. The accountholder/cardholder should ensure such charge will not cause the credit card account to exceed any established credit limits or available balances as on the date of charge. There will be a $25.00 penalty for any rejected charges pursuant to this authorization. Cardholder acknowledges that they will continue to be liable for any such rejected or any unpaid charges including all penalties. Cardholder further authorizes Company to initiate a charge or credit as necessary to correct any prior overpayment or underpayment of any invoice or any other charge or credit effected under this or prior authorization(s). Company and cardholder further acknowledge that if this payment authorization is for a recurring charge, then Company will inform cardholder of any variances in the recurring amount. Each charge will appear as a payment on the next statement to accountholder/cardholder after the charge date. Recurring charges will begin with the first statement we send the accountholder/cardholder after we receive this form.

-Note: The minimum charge for using Credit Cards is ten dollars ($10.00). If your monthly statement is less than $10.00, then a credit will be posted to your account.

-This authorization shall remain in effect until Pharmacy Direct Delivery, LLC receives in writing any changes in account information or termination of this authorization at least 15 days prior to the next billing date and Pharmacy Direct Delivery, LLC has had sufficient time to clear any arrears and act on the authorization. Cardholder will continue to be liable for any statements due and pending as of such termination. Cardholder is responsible for informing Company of any changes in the above information.

-If you have any questions on billing or credit card/ACH charges, please contact Pharmacy Direct Delivery, LLC , 434 Hurricane Lane, Williston, VT 05495, Tel: 802-655-3544, Fax: 802-655-0123