

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

Patient's Name:		Patien	nt's DOB:	
	AUTOMATIC	OPTION 1 ACH PAYMENT	AUTHORIZATION	
·				ount indicated below at the during the 1st week of each mont
Bank Name:			Type of account: 🔲 🕻	CHECKING SAVINGS
Routing Number:		Accou	ınt Number:	
Signature:			Date:	
Printed Name:		Phone	e Number:	
Email:				
	AUTOMATIC CRE	OPTION 2 DIT CARD PAYM	1ENT AUTHORIZAT	ON
·	armacy Direct Delivery, LLC ch month by way of my cred		•	ss my monthly statement charge ontrary 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 Addr	ess:			
Signature:			Date:	
date set forth above and subject specified above for the amounts b	to the terms and conditions set fort oilled to the account holder or cardh	h below, to charge the credition	t card, debit card, charge card or or critices and products providedCo	ompany") is authorized as of the authoriza other payment card (hereafter "credit card mpany will send the account holder or cified in the statement on the date of the

-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 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