



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: 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: Phone Number:
Email:

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.

-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.
-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