CREDIT CARD AUTHORIZATION FORM

M Chest Institutional Pharmacy Group, LLC ("MChest")

Instructions: Please complete this form if you wish to authorize MChest to maintain your credit or debit card on file and to bill your card for your supplies and medications.

Patient/Resident Name (Please Print): _____

Guardian or Financial POA Name (Please Print): _____
(Last, First and Middle Initial)

Mailing Address (Please Print): _____

Street, City, State, Zip _____

Phone: (_____)_____

Card Billing Address (Please Print): _____

Street, City, State, Zip _____

☐ (Check if it is the same as mailing)

I, (print name)_____, hereby authorize the use of my credit or debit card for payment of my prescriptions and/or other purchases.

This authorization is valid until (Date):_____/_____/_____
Month Day Year

Are you an authorized user of this Credit Card? ☐ YES ☐ NO

Please select one of the following options:

☐ Yes, I would like my Credit Card receipt mailed to me.
☐ No, I do not want my Credit Card receipt mailed to me.

_____ _____/_____/_____
SIGNATURE OF CARDHOLDER Month Day Year

OFFICE USE ONLY: Account Code: _ Location: _
NOTES:

Any changes must be submitted in writing to the address below.

CREDIT CARD INFORMATION WILL BE ENTERED INTO A SECURE ENCRYPTED DATABASE AND THIS HARDCOPY WILL BE DESTROYED

Please select card type:

☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

Credit Card #: _____

Expiration Date:_____ 3 Digit Security Code (from back of card)_____

Name as it appears on the credit card:_____

411 Main Street, Sulphur Springs, TX 75482
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