PAYMENT AUTHORIZATION FORM

I agree that Pharmacy Solutions may charge my credit card for charges for products and/or services. You authorize charges to your debit or credit card. You will be charged the amount indicated below. You agree that no prior-notification will be provided unless the date or amount changes, in which case you will receive notice from us prior to the payment being collected.

Please complete the information below:

_______________________________________ authorizes Pharmacy Solutions to charge the debit or credit card.

CREDIT CARD INFORMATION

- o MASTERCARD
- o VISA
- o DISCOVER
- o AMEX

Name as Appears on Card:____

Account Number: ____

Expectation Date :______________________________Security Code :

Billing Address ____
Address City Zip

AUTHROIZED SIGNATURE ____DATE ____________________

Initial ______ **I understand that this automatic debit will remain in effect for a minimum of 12 months from the date of when the agreement was signed after which it will continue each month until I cancel.** I agree to notify Kim Siegenthaler or Pharmacy Solutions in writing of any changes in my account information or termination of this authorization **at least thirty days prior to the next billing date**. If I do not notify Pharmacy Solutions thirty days in advance next billing cycle, I understand that the charge will process and I will be not be refunded. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank or credit card company; so long as the transactions correspond to the terms indicated in this authorization form.

Please email completed form to kim@rxcompound.com or fax to (817) 860-6083.

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