9731 G Southern Pine Blvd

Charlotte, North Carolina 28273

Phone: (888) 611-0844

Fax: (888) 611-0846

Credit Card Authorization Form

Guardian Pharmacy requests a valid credit card to be kept on file to secure each resident account in the event the medication charges become past due (over 60 days). This card will **ONLY** be charged if this situation occurs, unless we are advised otherwise to charge this automatically on a monthly basis as noted below.

Type of card (circle): Visa / Mastercard / American Express / Discover

Resident Name _____ Customer Number: _____

Name on card: _____Billing Address: _____

_____

Card # _____Expiration Date: _____Security Code* _____

*Visa/Mastercard/Discover: 3 digits on back of card

*American Express: 4 digits on the front of the card

☐ **I wish to pay automatically by credit card each month.** I authorize Guardian Pharmacy to charge my credit card for the balance of charges not paid by the insurance company. Guardian will charge the balance on/about the 15th of each month to allow time to review the statement and communicate any questions regarding the statement.

☐ I understand my credit card will only be charged after Guardian Pharmacy notifies me about non-payment of an outstanding balance.

Signature _____ Date: _____

Accepted by: Bruce Dann, President for Guardian Pharmacy