1412 SW 43RD STREET · Suite 120 · Renton, WA 98057
· (877) 425-6337 Phone www.readymedspharmacy.com
· (877) 509-6337 Fax readymedspharmacy@gmail.com
www.facebook.com/readymedspharmacy

Credit Card Authorization Form

Please print and complete all the information below.

Patient's Name: ______________________
Patient's Date of Birth: ______________________
Patient's Facility: ______________________

Name on Card: ______________________
Billing Address: ______________________
Billing City: ______________________
Billing State: ______________________
Billing Zip Code: ______________________
Email (optional): ______________________

Card Number: ______________________
Expiration Date: ______________________
CVV: ______________________
Type of Card: VISA MC AMEX DISC

I ____,
authorize Ready Meds Pharmacy to charge my credit card, outlined above, for any balance owed on the monthly statement for the client above. I understand that I will continue to receive monthly statements for my information and review. I acknowledge that Ready Meds Pharmacy will be storing my account on a secure server for billing purposes only.

I understand that upon receiving notification of the client leaving the facility or passing away, Ready Meds Pharmacy will charge any remaining balance on the client's file to close out the account.

I agree to pay the Pharmacy a fee of $40.00 if for any reason I issue a chargeback with my credit card company.

Patient / POA Signature: ______________________
Patient / POA Printed Name: ______________________
Date: ______________________