Ready Meds Pharmacy
Renton • Spokane • Lacey • Everett

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ACH Authorization Form

Please print and complete all the information below.

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

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

Name of Bank:
Routing Number:
Account Number:
Type of Account: ☐ Checking ☐ Saving

I _____,
authorize Ready Meds Pharmacy to charge my account, 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 debit any remaining balance on the client's file to close out the account.

I agree to pay the Pharmacy a fee of $40.00 per RCW 62a.3-515 (b)(1) if for any reason my payment is not honored by my financial institution.

Account Holder Signature:
Account Holder Printed Name:
Date:

* Please attach a copy of a voided check