Pharma Pac
Point-of-Care Dispensing Solutions

Pharma Pac
1400 W. Grand Ave., Suite F, Grover Beach, CA 93433
T 805-929-1333 F Fax: 805-929-6036

CREDIT CARD AUTHORIZATION AGREEMENT

The undersigned medical provider does hereby authorize Pharma Pac (Company) to charge the credit card, shown below, for the amount of invoiced purchases. In the case of a discrepancy, please bring to the attention of the Company, in writing, within three (3) business days following the receipt of product. The charges will be administered automatically by the Company on the due date of the invoice.

Customer Name:_____

Pharma Pac Account No. _____

Credit Card Information:

_____ _____
Name as it appears on credit card | Credit Card Billing Street Address

_____ _____
Telephone Number (on file with Credit Card Co.) | City, State, Zip Code

Credit Card Type: ☐ MasterCard ☐ Visa ☐ American Express

Credit Card Number: _____-_____-_____-_____-

Security Code: _____ Expiration Date: _____ / _____
M M Y Y

Authorized Signature _____ Date _____

This authorization will remain in force until cancelled by written notification.

Please complete and return this form by fax to: 805-929-6036