Credit Card Consent

Resident Name: _____

Last First Middle Initial

Facility Name: _____ Customer Number: _____

I authorize **Middle Tennessee Pharmacy Services** to charge my credit card for the balance of charges not paid by my insurance company.

☐ This service only, not to exceed $_____.

Cardholder's Name: _____

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

Card Number:

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Expiration Date:

☐ ☐ ☐ ☐

Cardholder's Billing Address:

_____

CVN*:

☐ ☐ ☐

*Card Verification Number. Found on back of card, need only last 3 digits.

I understand that this form is valid for the time period selected above unless I cancel the authorization through written notice to Guardian Pharmacy.

Cardholder Signature:_____ Date:_____

Note that balances will be charged after statements have been received by customers to allow for the communication of any issues/concerns. Guardian will automatically process payments in accordance with instructions outlined above before the next statement is generated unless otherwise instructed.