PATIENT CARE PHARMACY SERVICES, INC.

1476 MARKET CIRCLE, UNIT 1, PORT CHARLOTTE, FL 33953
PH. (941) 255-1987 • (800) 306-3784 • FAX: (941) 629-5507

SERVICE AUTHORIZATION FORM

The return of this form, with all parts completed, and all requested materials to the pharmacy in a timely manner will prevent a delay in service

Resident And Billing Information:

RESIDENT NAME: **FACILITY:**_____

First:_____ **Middle:**_____ **Last:**_____

Social Security Number:_____ - _____ - _____ **Date of Birth** (MM/DD/YYYY):_____

Responsible Party: Name:_____

Mailing Address for Statements: Street or P.O. Box:

_____

City:_____ **State:**_____ **Zip Code:**_____

Relationship to Resident:_____ **Phone #:**_____

Cell#:_____ **Fax#**_____

Email Address:_____

Payment Option: **We require that each account have a responsible party/guarantor (other than resident), otherwise the account must be secured by a debit/check card or credit card. Your choices for doing this are below, please select one and provide complete debit/check card or credit card and or other information in the space provided. If paying by debit/check card or credit card, I authorize Patient Care Pharmacy to bill my debit/check card or credit card:**

_____ **Bill the debit/check card or credit card below on a monthly basis for the amount reflected on the statement sent to me, I understand that a statement is generated on the a specified day for facility and that this card will be charged on the next business day for the full amount, unless I contact the pharmacy prior to this date. If you select this option please do not send a check for payment when you receive the statement in the mail.**

_____ **Bill the debit/check card or credit card for any amount that remains unpaid after thirty (30) days from the date on the most recent statement for the full balance over thirty (30) days past due.**

_____ **Check payment (due in full within thirty (30) days of statement date)**

We accept all major credit cards, and debit/check cards which have a Visa or Mastercard Logo attached to them.

Credit Card (*circle one*): **VISA** **Mastercard** **Discover** **American Express**

Name on Card:_____

Credit Card Number:_____ **Expiration Date:**_____

CVV # (3 or 4 Digit Verification): _____

Mailing Address for Credit Card: Street or P.O. Box: _____

City:_____ **State:**_____ **Zip Code:**_____

Phone#:_____

Signature of Cardholder:_____

I have read the terms and conditions stated herein and agree to all of these terms and conditions and authorize payment of past due balances as indicated above.