ROCKHILL PHARMACY
LONG TERM CARE SERVICES

ROCKHILL PHARMACY AUTHORIZATION AGREEMENT
FOR AUTOMATIC PAYMENTS

I, _____, hereby authorize Rockhill Pharmacy to initiate automatic payments for my pharmacy account based upon the monthly statement. I understand that monthly statements are generated and mailed/emailed within the first 3 business days of each month.

Payment authorization:

Amount to be processed: ☐ Current Statement Balance ☐ Set Amount: _____

Date to be processed each month: _____

If necessary, I also authorize credits/adjustments to the account/card indicated below. I acknowledge that the origination of ACH and credit card transactions to the account/card indicated below must comply with the provisions of U.S. law.

BANK ACCOUNT: ☐ Checking ☐ Savings

Financial Institution:_____ _____ Phone Number: _____

Address/City/State/Zip: _____

Routing Number: _____ Account Number:_____

CREDIT CARD: ☐ VISA ☐ MASTERCARD ☐ DISCOVER

Cardholder Name: _____ Card No.: _____-_____-_____ Exp: _____ CVC:_____

This authority is to remain in full force and effect until Rockhill Pharmacy has received written notification of termination in such time and manner as to afford Rockhill Pharmacy and Financial Institution (if applicable) a reasonable opportunity to act.

Individual/Authorized Representative:

NAME: _____SIGNATURE: _____

DATE: _____

***** *PLEASE ATTACH A VOIDED CHECK HERE IF APPLICABLE* *****