ANDREWS PHARMACY
324 Weston Rd, Wellesley, MA, 02482
Tel. 781-235-1001 Fax. 781-239-0655
andrewspharmacy@hotmail.com

CREDIT CARD BILLING AUTHORIZATION FORM

Credit Card Billing Information

Patient Name:____

Credit Card Type:
- VISA [ ]
- MasterCard [ ]
- American Express [ ]
- Discover/Novus [ ]
- Other, please Specify:______________________________

Credit Card Number:____

Cardholder's Name:____

Credit Card CVC Number (3 Digit Number on Reverse of Card:______________

Expiration Date:_______/_________

Billing Address:________________________________

City:____

State:_______________________________________

ZIP Code:____________________________________

Country:_____________________________________

Phone Number:________________________________

Work Number:_________________________________

MONTHLY BILLING AUTHORIZATION

I hereby authorize ANDREWS WEST INC, dba ANDREWS PHARMACY to bill my credit card account on a once monthly basis for products and services provided. Applicant agrees that all information provided is accurate and complete.

Signature:_______________________________________ **Date:**____/_____/_______