Glenwood South
PHARMACY MARKET

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information			
Card Type:	☐ MasterCard	☐ VISA	☐ Discover	☐ AMEX
	☐ Other _____		
Check if HSA or FSA:	☐ HSA	☐ FSA	
Cardholder Name (as shown on card):			
Billing Street Address:			
Billing City/State/Zip:			
Card Number:			
Expiration Date (mm/yy):			
Security Code:			

I,_____, acknowledge and assume responsibility and grant authorization for Payless Pharmacies, Inc. "Glenwood South Pharmacy + Market" to charge my credit card for the cost of any medication not covered by patient's insurance company, as well as any co-insurance and deductibles and charges for requested OTC items. I authorize the pharmacy to contact my insurance company for insurance verification, billing, and collections for my medications. All personal information will be solely maintained for the purposes of dispensing prescriptions and insurance collection and payment.

_____ _____

Name of Patient (Please Print) Name of Cardholder (Please Print)

_____ _____

Cardholder Signature Date

SUBMIT FORM BY:
MAIL: 401 GLENWOOD AVE STE 101, RALEIGH NC 27603
FAX: (919) 615-0949
CALL: (919) 856-9502