CREDIT CARD AUTHORIZATION FORM

I authorize Parkway Pharmacy, Inc. to charge my credit card for the total amount of monthly medications and/or over-the-counter items for the following person(s)

Patient Name:
Cardholder's Name: (as it appears on the credit card):
Cardholder's Billing Address:
City/State/Zip:
Phone Numbers:
Home: Work: Cell:

CREDIT CARD INFORMATION:

Type of Card (circle one): American Express Discover Visa Master Card
Credit/Debit Card Numbers:
Expiration Date:

→ Signature: Date: