ELECTRONIC CHECK (E-CHECK) PAYMENT AUTHORIZATION FORM

Please sign and complete this form to authorize Parkway Pharmacy to make a monthly debit from your bank account. Once you have completed this form you ***MUST*** attach a voided check of the account you wish us to debit from for verification and security purposes.

By signing this form you give Parkway Pharmacy permission to debit your account the total amount due as indicated on your monthly Parkway Pharmacy statement.

For your initial setup a completed authorization form along with a voided check must be submitted. Written cancellation of this agreement must be submitted to our office within 5 business days of the next scheduled debit.

*****PLEASE COMPLETE THE INFORMATION BELOW*****

I_____authorize Parkway Pharmacy, Inc. to charge my bank account indicated below the total amount due as indicated on my monthly Parkway Pharmacy statement.

Name of Resident:
Name on Bank Account:
Bank Account Number:
Bank Routing#
Bank Name:
Bank City/State

**In the case that a transaction is returned for Non-Sufficient Funds (NSF) I agree to a $36.00 bank fee *plus* an additional $30.00 or 10% (whichever is greater) electronic check processing fee **

→ Signature:
Name (printed):
Date: