

AUTHORIZATION AGREEMENT FOR AUTOMATIC PAYMENTS



OPTION #1 ACH (Automated Clearing House):

I (We) hereby authorize GOOD DAY PHARMACY, to initiate debit entries to my (our) account indicated below at the depository financial institution named below, and to debit the same to such account. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law.

***PLEASE ATTACH A VOIDED CHECK TO IDENTIFY YOUR BANK INFORMATION BELOW**

ATTACH VOIDED CHECK HERE:

Name of Financial Institution: _____ Routing Number (9 digits): _____ Account Number: _____

OPTION #2 (Recurring Card Payment):

If you prefer to have charges billed to your card, please fill in the spaces below.

I (We) hereby authorize GOOD DAY PHARMACY, to charge the card information provided.

Credit Cards will be assessed a 2.99% processing fee.

<u>Circle One:</u>	Credit Card	Debit Card	HSA / FSA
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Name on Card: _____

MasterCard / Visa / Discover #: _____ - _____ - _____ - _____

Expiration Date: ____/____ / ____ 3-Digit Security Code: ____ Zip Code : _____
(Mo) (Yr)

Complete for Authorization:

This authorization is to remain in full force and effect until GOOD DAY PHARMACY has received written notification from me (or either of us) of its termination in such time (at least five (5) business days) as to afford GOOD DAY PHARMACY and DEPOSITORY a reasonable opportunity to act on it.

Name _____ Resident Name _____
(Please Print) (Please Print)

Signature _____ Community Name _____

Email _____ Date _____