West TN Pharmaceutical Care
Credit Card Consent

Customer Name:_____

Facility/Agency Name:_____Customer No:_____

I authorize **West TN Pharmaceutical Care, LLC** to charge my credit card for the balance of charges not paid by my insurance company.

_____This one time service for $_____ or_____Monthly on this date_____

Card Holder Name:_____

Card Holder Billing Address:_____

City/State/Zip:_____

Type of Card: Visa/Mastercard/Discover/American Express

Card Number:_____

Expiration Date:_____

CVV*:_____*Card Verification Value, the 3 or 4 digit number on card

I understand that this form is valid for the time period selected above unless I cancel the authorization notice with WTPC.

Card Holder Singature:_____Date:_____

Note that balances will be charged after statements have been received by customers to allow for the communication of any issues/concerns. WTPC will automatically process payments in accordance with instructions outlined above before next statement is generated unless otherwise instructed.

Please fax completed form back to: 731-554-9874 or scan and email to: fax@wtnpc.com Thank you.