INDEPENDENT PHARMACEUTICAL

854 E Crescentville Rd.
West Chester, Ohio 45246
Phone: 888-258-5036 Fax: 844-668-8628
compliance@independentpharma.com

Credit Card Authorization

Complete all sections that apply.

☐ ***I would like Credit Card terms.*** (circle 1 option below)

1- Charge card when order ships.
2- Charge card when bill is due.
3- Charge entire statement to my card Once per month.

☐ ***I would like to remain Net 30 day terms***:

I hereby authorize Independent Pharmaceutical to charge the following to my credit card:

Invoice#(s):_____

Total:_____

Method of Payment:

☐ MasterCard ☐ Visa ☐ American Express

Card Number:_____CVV2:_____

Expiration Date: _____

Card Holder's Name:_____

Billing Address:_____

_____

Business Name:_____

Customer ID:_____

Below is Optional for customers with "Net 30 day terms"

Providing a signature below authorizes Independent Pharmaceutical to keep this credit card on file for future payments as requested above.

Authorized User's Name (Please Print):_____

Authorized User's Signature: Date: