



INDEPENDENT PHARMACEUTICAL

Independent Pharmaceutical
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West Chester, Ohio 45246
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Payment Authorization Form

Customer Information

Business Name:	
Customer ID:	
Phone / Email:	

Payment Method

ACH (Automatic Bank Draft)	
Bank Name:	
Routing Number:	
Account Number:	
Account Type:	<input type="checkbox"/> Checking <input type="checkbox"/> Savings
Billing Address:	
Credit Card	
<input type="checkbox"/> MasterCard <input type="checkbox"/> Visa <input type="checkbox"/> AmEx	
Card Number:	
CVV:	
Expiration Date:	
Name on Card:	
Billing Address:	

Payment Terms (choose one)

- Charge when order ships (ACH or Credit Card)
 Charge when bill is due – Net 7 (ACH or Credit Card)
 Charge when bill is due – Net 15 (ACH or Credit Card)
 Net 30 Terms (ACH only)

Authorization

Authorized User's Name (Print):			
Signature:		Date:	

By signing this form, you authorize Independent Pharmaceutical to initiate ACH or credit card transactions from the account provided. All payment information provided will be securely kept on file and may be used for processing payments in accordance with the terms selected. If a transaction is returned unpaid (NSF or otherwise), Independent Pharmaceutical may attempt to reprocess the payment within 30 days. A return/NSF fee of \$15 will be applied to each occurrence. You remain responsible for all amounts due, including any fees, until paid in full. This authorization will remain in effect until revoked in writing. You agree to comply with U.S. law governing electronic payments and credit card transactions.