



INDEPENDENT PHARMACEUTICAL

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

One Time Credit Card Draft Authorization Form

I hereby authorize Independent Pharmaceutical to charge the following order #(s) to my credit card.:

Order # _____	Total: _____	Order # _____	Total: _____
Order # _____	Total: _____	Order # _____	Total: _____
Order # _____	Total: _____	Order # _____	Total: _____
Order # _____	Total: _____	Order # _____	Total: _____

Method of Payment:

MasterCard Visa American Express

Card Number: _____ CVV2: _____

Expiration Date: _____

Card Holder's Name: _____

Billing Address: _____

Pharmacy Name: _____

Account Code: _____

Optional

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

Authorized User's Name (Please Print): _____

Authorized User's Signature: _____ Date: _____