Williams Bros.
HEALTH CARE PHARMACY
Focused on your health since 1899.

PAYMENT AUTHORIZATION FORM

Please provide the following in order for us to contact you with **important information** about your account.

Responsible Party Information

Patient Name: _____ Account Number: _____ Dept.: _____

Responsible Party Name: (if different than patient) _____

Street Address: (billing address) _____

City: _____ State: _____ Zip: _____

Email Address: _____ ☐ Please deliver all future billings via Email

Home Phone: _____ Mobile Phone: _____

If calling or texting your mobile number is not acceptable to you, please check the corresponding boxes below:

☐ Do not call my mobile number ☐ Do not text my mobile number

Payment Authorization for Automatic Payment

Our financial policy requires patients to have a form of payment on file to satisfy any patient responsibility. If you have provided insurance coverage to us, we will bill your insurance company with the necessary information. The balance remaining after insurance has been applied is your responsibility, including insurance deductible amounts. Our office will send an invoice to you once your patient balance is determined. The credit card or bank account listed below will be automatically charged on the due date specified on your next invoice.

Provide either Credit Card or eCheck information:

Credit Card		eCheck	
Credit Card number		Your bank account number	
Expiration date		Bank routing number	
CVV code (3 digits on back)		Bank name	
Name on card		Name on check	
Address Information for Card (if different than above)		Address Information on Check (if different than above)	
Street Address		Street Address	
City		City	
State		State	
Zip		Zip	

I authorize Williams Bros. Health Care Pharmacy to execute transactions on the above account. I consent to the use of the above payment method without my signature on the individual transactions in satisfying my obligations to Williams Bros. Health Care Pharmacy. I understand that a photocopy or fax of this agreement will serve as an original, and this payment authorization cannot be revoked unless done so in a 30 day written notice to the Provider.

RESPONSIBLE PARTY SIGNATURE: _____

DATE: _____