DIRECT PAYMENT AUTHORIZATION FORM

This form authorizes regularly scheduled payments to be made from your checking or savings account or credit card. Your payments will be made automatically on the specified day and proof of payment will appear on both your bill as well as the statement you receive from your financial institution.

The authority you give to charge your account will remain in effect until you notify us in writing to terminate the authorization.

CLIENT INFORMATION

Name______________________________ Facility________________________

RESPONSIBLE PARTY

Name______________________________ E-mail address________________

Address______________________________ Phone________________

______________________________ Best time to call____________

CREDIT CARD PAYMENT AUTHORIZATION

Master Card _____ VISA _____ American Express _____ Discover _____

Credit Card Number______________________________

Expiration Date________________ Name on card________________________

Signature______________________________ Date____________

SAVINGS or CHECKING ACCOUNT DEDUCTION PAYMENT AUTHORIZATION (attach a voided check)

Account Number______________________________

Savings________ Checking________

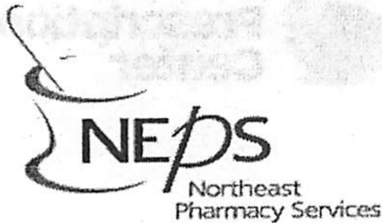
Financial Institution Routing Number________________________

Financial Institution Name________________________

Financial Institution City & State________________________

I authorize Northeast Pharmacy Services to initiate electronic debit entries to my account for payment of my pharmacy bill and The Prescription Center to initiate electronic debit entries for payment of my medical supplies bill.
I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. This authority will remain in effect until I have cancelled it in writing.

Signature______________________________ Date____________



GUARANTY: I understand that all bills are due and payable within term specific below. Past due accounts are subject to a finance charge which is computed by period rate of 1 1/2% per month on all unpaid balances. There is an annual percentage rate of 18%. I understand that if credit is approved that I agree to pay Northeast Pharmacy Services and/or The Prescription Center within the terms and condition of sale (net amount due at Northeast Pharmacy Services and/or The Prescription Center within fifteen (15) days of billing).

STATEMENT: I have carefully read the foregoing statement and it is a complete, true and correct statement to the best of my knowledge and belief. I do understand that Northeast Pharmacy Services and/or The Prescription Center will rely on this statement to the extent any credit given and without this application no goods would be advanced. I also understand that in the event of any default, I will be responsible for all costs of collection including reasonable attorney fees.

COLLECTION: I hereby guaranty payment of all indebtedness incurred on this account and agree to be responsible for all cost of collection and attorneys and principle amount due for any default. I also agree that Northeast Pharmacy Services and/or The Prescription Center do not have to exhaust any remedy in order to collect this sum from me prior to invoking this guaranty.

CREDIT INFORMATION: I hereby give my consent to Northeast Pharmacy Services and/or The Prescription Center and/or their assigned credit bureau to obtain any and all information regarding my employment, checking and/or savings accounts, credit obligations, and all other credit matters which may be required in connection with my application for credit. In the event my application is approved, I also give consent to Northeast Pharmacy Services and/or The Prescription Center and/or their assigned credit bureau to obtain additional credit reports and any other information after approval of my credit, both in connection with the same transaction or an extension of credit; also for purposes of reviewing the account; for the purposes of increasing the credit line on the account; for the purposes of taking collection action on the account; and for other legitimate purposes associated with the account.

Signature______________________________ Date______________

Print Name______________________________