Pharmsource, LLC
Value, Experience, Integrity

Payment Authorization Form

COMPANY NAME: _____ **ACCOUNT NUMBER:**_____

EMAIL ADDRESS: _____ **PHONE NUMBER**: _____

Payment Options (check one):

☐ **ONE TIME USE ONLY:** This authorization is valid for this transaction only. The transaction amount will be $_____(transaction amount required).

☐ **AUTO CHARGE ON DUE DATE;** This is an open authorization to allow charges to my account for amount(s) which will vary per transaction(s).

☐ **PREPAY:** This is an authorization to allow charges to my account for amount(s) which will vary per transaction(s) at the time of shipment.

Select the Preferred Payment Method: (check one):

☐ **ACH DRAFT** (**PLEASE ATTACH A COPY OF VOIDED CHECK TO COMPLETED FORM**)

☐ **CREDIT CARD**

☐ I opt for an additional 2% convenience fee when paying with credit card

Credit Card Number:_____**Exp Date**: _____/_____ **CVV**: _____

Bill To Name and Address: _____

_____

The undersigned owner or authorized officer of the entity reflected below ("Customer") does hereby authorize Pharmsource, LLC, and its affiliates, subsidiaries, and divisions ("Pharmsource") to charge the credit card or debit the bank account listed above. The amount and date of each such charge shall be reflected on the invoice received from Pharmsource, unless a dispute with respect to such invoice is brought to the attention of Pharmsource, in writing within 3 business days from the receipt of goods from Pharmsource. This authorization shall continue until the reflected charge card (or replacement thereof) expires or until you receive my written notification of cancellation.
Customer understands that because these are electronic transactions, these funds may be withdrawn from Customer's account as soon as the above noted periodic transaction dates. If an ACH Transaction is rejected for Non-sufficient Funds (NSF), Customer agrees to pay an additional $30.00 (Thirty dollar) charge for each returned NSF item, which charge shall be initiated as a separate transaction from the authorized payment. Customer further understands and agrees that Customer's account with Pharmsource will be frozen in such event, and that pending orders will not be filled, and Customer will not be able to place new orders, until a replacement payment and the referenced NSF charge is paid to Pharmsource in good and available funds.

This authorization shall continue until written notification is received by Pharmsouce, LLC to cancel it.

Authorized Signature:

_____ **Date** _____

Your payment method will be charged by Pharmsource, LLC on the due date of the invoice(s)

PLEASE FAX THE COMPLETED FORM TO (912) 216-0605