528 N. Broadway
Escondido CA 92025

Advance Care
PHARMACY

Phone: 760.489.7077
Fax: 760.489.7040

ELECTRONIC CHECK PAYMENT

Complete the following authorization and attach a voided check.

Tape copy of voided check here

(Do not staple)

Name (please print): _____

Facility Name: _____

Email address: _____ @ _____

Name of Bank: _____

Bank Routing # _____

Checking Account # _____

I authorize C&A Medical 1 dba Advance Care Pharmacy to initiate debit entries to my( ) checking ( ) savings account(s) at the financial institution listed above through the Electronic Funds Transfer process, to transfer a monthly payment for monthly Prescription and Pharmacy charges to their bank. I understand this amount will show up on my bank statement for the purposes of payment and amount verification. I understand this authority is to remain in full force and effect until C&A Medical 1 (Advance Care Pharmacy) has received written notification from me of its termination in such time and in such manner as to afford the depositor a reasonable opportunity to act on it. I maintain the right to stop payment of the debit entry (deduction) by written notification mailed (10) business days or more before this payment is scheduled to be made.

Mail to:
Advance Care Pharmacy
528 N. Broadway
Escondido, CA 92025
Tel: (760) 489-7077 Fax: (760) 489-7040
Email: advancecarerx@yahoo.com

_____

Signature (required) Date