AUTOMATIC PAYMENT FORM

Resident Name: _____
[first] [middle] [last]

Credit Card Payment Information

A valid credit card is required to be kept on file to secure this account.

TYPE OF CARD (circle): VISA MASTERCARD AMERICAN EXPRESS DISCOVER

NAME ON CARD: _____ CARD NUMBER: _____

BILLING ADDRESS: _____ EXPIRATION DATE (MM/YY): ____/____

_____ SECURITY CODE: _____

**VISA/MC/DISCOVER: 3 digits on back of card
**AMEX: 4 digits on front of card

Direct Withdrawal Checking Account Information

FULL NAME ON ACCOUNT: _____

ROUTING NUMBER: _____

ACCOUNT NUMBER: _____

Please select an option below and sign

- ☐ I wish to pay automatically by credit card each month – please enroll me in autopay
- ☐ I wish to pay automatically by checking account each month – please enroll in autopay
- ☐ I will mail in payment by check or call to pay by phone each month, promptly after receipt of Guardian Pharmacy's statement

*If payment is not received from resident within 60 days, Guardian Pharmacy will attempt to contact the responsible party. After which, if payment still has not been received, payment will be drafted from card on file. Credit card will only be used after Guardian Pharmacy notifies responsible party of non-payment of an outstanding balance. Guardian Pharmacy reserves the right to withhold services if payment is 90 days or more past due and no good faith effort has been made to bring the balance current. Payments that remain delinquent may be turned over to collections and reported to credit reporting agencies.

Resident/Responsible Party Signature: _____
Date of Birth: _____ Date: _____

Please return by email at ordersmic@guardianpharmacy.net; fax: 616-974-8205; or mail to
Guardian Pharmacy of Michigan
Attn: Billing Department
2930 29th Street SE
Grand Rapids, MI 49512