Personal Rx

Credit Card Authorization

This form must be completed for all credit cards submitted.
Fax: (201) 334-0700 or email to support@personalrx.com

Card Type (Visa, MasterCard, American Express, Discover)	
Check if HSA or FSA Card?	HSA [ ] FSA [ ]
Billing Address Check if same as shipping address [ ]	
Name on Card	
Card Number	
Expiration Date	
Security Code	

I acknowledge and assume responsibility and grant authorization for DGN Pharmacy, Inc./ PersonalRX/ GroupRX "Pharmacy" to charge the above credit card for the cost of any medication not covered by patient's insurance company, as well as any co-insurance and deductibles and charges for requested OTC/Sundries or non-standard delivery services. I authorize the pharmacy to contact my insurance company for insurance verification, billing, and collections for my medications. As per the HIPPA agreement (available online at www.PersonalRX.com) all personal information received will be solely maintained for the purposes of dispensing prescriptions and insurance collection and payment. I understand that I am responsible for the costs of all medication changes received after a prescription has been filled or packaged.

"PATIENT RIGHT TO COUNSEL" NOTIFICATION
We invite you to use our toll-free number to contact a PersonalRX pharmacist regarding any questions you may have about your prescription medication. For urgent needs, you may reach a PersonalRX pharmacist at any time.

Name of Patient (Please Print):_____

Signature of Guarantor/Cardholder:_____

Date:_____