CREDIT CARD AUTHORIZATION

This form must be completed for EACH credit card 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
Name on Card:	
Billing Street Address	
City/State/Zip	
Card Number:	
Expiration Date:	
Security Code:	

I acknowledge and assume responsibility and grant authorization for PersonalRX / DGN Pharmacy, Inc. "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: _____

Name of Cardholder (Please Print): _____