College Pharmacy
Compounding Specialists

Credit Card Authorization Form

In order to ensure that orders get processed in a timely manner, please complete this form and return to College Pharmacy via fax (800-556-5893), eFax (866-480-7483) or email (customerservice@collegepharmacy.com), along with a copy of the front of the credit card (ensuring that the full name and last 4 digits of the card are visible).

BILLING INFORMATION:

Name on Card: _____

Billing Address: _____

_____

Telephone: _____ Email: _____

Credit Card Type: ____Visa ____Mastercard ____AmEx ____Discover

Last 4 Digits of Credit Card Number: _____

Expiration Date: _____

Items Purchased: ____OTC Product(s)
____Compounded Prescription(s)
____Medical Device

Amount to Charge: $_____

I authorize College Pharmacy to charge the amount listed above to the credit card provided herein. I agree to pay for this purchase in accordance with the issuing bank cardholder agreement.

Cardholder - Please Sign and Date

Signature: _____

Date: _____

Print Name: _____

Please send completed form, along with a scan of the FRONT of the credit card (making certain that the FULL NAME and LAST 4 DIGITS of the credit card are visible) to us by fax or email

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3505 Austin Bluffs Pkwy., Ste. 101
Colorado Springs, Colorado 80918
www.collegepharmacy.com

Tel:800-888-9358 / 719-262-0022
Fax:800-556-5893 / 719-262-0035
customerservice@collegepharmacy.com
eFax: 866-480-7483