



CREDIT CARD PAYMENT AUTHORIZATION

I authorize Red River Pharmacy to auto charge my credit card every month until balance is paid in full. In the amount of \$ _____ on the _____ of the month x _____ payments.

TOTAL CHARGE: _____ FIRST PAYMENT STARTS: _____

Date:	
Account #	
Name and address of card holder	
Visa, MasterCard, or Discover	Discover
Credit Card Number	
Expiration date	
CVV code (security code on back of card)	
Signature:	

*******PLEASE COMPLETE AND RETURN BY FAX TO (903)-793-0485 OR MAIL TO RED RIVER PHARMACY, 1550 Moores Lane, TEXARKANA, TX 75503*******