HHCRx

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Cincinnati, OH 45240

PAYMENT AUTHORIZATION FORM

(Please print in block letters)

CUSTOMER INFORMATION

Company Name: _____ **Account #:** _____

Email: _____ **Phone:** _____

PAYMENT OPTIONS *(CHECK ONE)*

☐ **ONE-TIME USE ONLY:** This authorization is valid for this transaction only. The transaction amount will be $_____(transaction amount required).

☐ **AUTO CHARGE ON DUE DATE:** This is an open authorization to allow charges to my account for amount(s) which will vary per transaction(s).

☐ **PREPAY:** This is an authorization to allow charges to my account for amount(s) which will vary per transaction(s) at the time of shipment.

SELECT THE PREFERRED PAYMENT METHOD *(CHECK ONE)*

☐ **ACH** (please attach a copy of a voided check to the completed form)

☐ **CREDIT CARD** (by paying with a credit card, an additional 3% convenience fee will be applied to the transaction)

Name on Credit Card: _____

Credit Card #: _____ **EXP:** _____ **CVV:** _____

Bill to Name: _____

Billing Address: _____

City: _____ **State:** _____ **Zip:** _____

The undersigned owner of authorized officer of the entity reflected below ("Customer") does hereby authorize HHCPharma, LLC. and its affiliates, subsidiaries, and divisions ("HHCPharma") to charge the credit card or debit the bank account listed above. The amount and date of each such charge shall be reflected on the invoice received from three business days from the receipt of goods from HHCPharma. This authorization shall continue until the reflected charge card (or replacement thereof) expires or until you receive my written notification of cancellation.

Customer understands that because these are electronic transactions, these funds may be withdrawn from Customer's account as soon as the above noted periodic transaction dates. If an ACH transaction is rejected for Non-sufficient Funds (NSF), Customer agrees to pay an additional $30 charge for each returned NSF item, which charge shall be initiated as a separate transaction from the authorized payment. Customer further understands and agrees that Customer's account with HHCPharma will be frozen in such event, and that pending orders will not be filled, and Customer will not be able to place new orders, until a replacement payment and the referenced NSF charge is paid to HHCPharma in good and available funds.

Your payment method will be charged by HHCPharma on the due date of the invoice(s). This authorization shall continue until written notification is received by HHCPharma, LLC. to cancel it.

Authorized Signature: _____

Print Name: _____

Title: _____ **Date:** _____

(By signing, you represent that you have sufficient authority to execute this application on behalf of the applicant and bind the applicant to the terms hereof.)

Please send the completed form to your **HHCPharma Representative.**
If you have any questions/concerns call **855.428.3055.**