



Contact Info:
 Address: 661 East Lane St.
 Shelbyville, Tn 37160
 Phone: 877-684-9987

Credit Card Consent

Resident Name: _____

Last

First

Middle Initial

Facility Name: _____

Customer Number: _____

I authorize **Middle Tennessee Pharmacy Services (Billing Dept. for Guardian Mid-South)** to charge my credit card for the balance of charges not paid by my insurance company.

This service only, not to exceed \$_____.

Cardholder's Name: _____

Type of card (circle) Visa/ Mastercard / American Express / Discover

Card Number:

Expiration Date:

Cardholder's Billing Address:

CVN*:

*Card Verification Number. Found on back of card, need only last 3 digits.

I understand that this form is valid for the time period selected above unless I cancel the authorization through written notice to Guardian Pharmacy.

Cardholder Signature: _____ Date: _____

Note that balances will be charged after statements have been received by customers to allow for the communication of any issues/concerns. Guardian will automatically process payments in accordance with instructions outlined above before the next statement is generated unless otherwise instructed.