



925 E Covey Lane
Phoenix, AZ 85024
(623) 815-8965

One Time Credit Card Payment Authorization Form

Sign and complete this form to authorize Saliba's Extended Care Pharmacy to make a one-time charge to your credit card listed below.

By signing this form, you give us permission to charge your account for the amount indicated on or after the indicated date. This is permission for a single transaction only and does not provide authorization for any additional unrelated debits or credits to your account.

Please complete the information below:

I _____ authorize Saliba's Extended Care Pharmacy to charge my credit card
(full name)
account indicated below for _____ on or after _____. This payment is for
(amount) (date)
_____.
(description of goods/services)

Billing Address _____
City, State, Zip _____

Phone# _____
Email _____

Account Type: ☐ Visa ☐ MasterCard ☐ AMEX ☐ Discover

Cardholder Name _____

Account Number _____

Expiration Date _____

CVV2 (3 digit number on back of Visa/MC, 4 digits on front of AMEX) _____

SIGNATURE _____

DATE _____

I authorize the Saliba's Extended Care Pharmacy to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above, for the amount indicated above only, and is valid for one time use only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

PLEASE FAX THE COMPLETED CREDIT CARD PAYMENT AUTHORIZATION FORM TO (623) 469-6262.

Your card will be charged the day prior to the event.