Republic Pharmaceuticals
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Ann Arbor, MI. 48103
Hours: Monday- Friday 10am-5pm

Email: customerservice@republicpharma.com
Phone: 800-659-6609 ext.113
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Recurring Payment Authorization Form

Schedule your payment to be automatically deducted from your bank account, or charged to your Visa, MasterCard or American Express. Just complete and sign this form to get started!

OPTION: NET 30-CHECK ☐ Must list a **backup** form of payment below.

Recurring Payments Will Make Your Life Easier:

- It's convenient (saving you time and postage)
- Your payment is always on time (even if you're out of town), eliminating late charges

Here's How Recurring Payments Work:

If you do not choose NET 30- CHECK TERMS, you authorize regularly scheduled charges to your checking/savings account or credit card. You will be charged the amount indicated below each billing period. A receipt for each payment will be emailed to you and the charge will appear on your bank statement as an "ACH Debit." **You agree that no prior-notification will be provided unless the date or amount changes, in which case you will receive notice from us at least 10 days prior to the payment being collected.** **Credit Card payments are done at Point-of-Sale and are required for all online purchases if ACH is not specifically specified.** ***If a credit card becomes invalid the order will be held for 24 hours before it is canceled.*** **Product ordered on the 1st- 25th is drafted as **ACH** on the 10th of every month.**

Please complete the information below:

Medical Facility or Pharmacy Name: ____

Billing Address City, State, Zip: ____

Phone Number: _________________________ Email (required): ________________________

Checking/ Savings Account

☐ Checking ☐ Savings

Name on Acct: ___________________________

Bank Name: ___________________________

Account Number ___________________________

Bank Routing # ___________________________

Bank City, State ___________________________

Credit Card

☐ Visa ☐ MasterCard

☐ Amex

Business Cardholder Name as It Appears on the Card:

____

Card Number: ____________________________

Exp. Date: ______________ CVV: ______

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Republic Pharmaceuticals in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. For ACH debits to my checking/savings account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Non-Sufficient Funds (NSF) I understand that Republic Pharmaceuticals may at its discretion attempt to process the charge again within 30 days and agree to an additional $50 charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank or credit card Company; so long as the transactions correspond to the terms indicated in this authorization form.

Print Name _________________________ **SIGNATURE**______________________________ **DATE:**___________