AUTO CREDIT CARD AUTHORIZATION

Resident Name: ____

Facility Name: ______________________ Patient Code: ______________________

Date of Birth: ______________________ Social Security #: ______________________

GUARANTOR / CREDIT CARD HOLDER

Name: ______________________ Home# ______________________

Address: ______________________ Work# ______________________

City/State/Zip : ______________________ Relationship: ______________________

CREDIT CARD INFORMATION

Account #: ______________________ Exp. Date: ______________________

Card Type: ______________________ CVV2/CVC2/CID : ______________________

I AUTHORIZE GREAT NECK CHEMISTS INC OF NY, TO PAY THE ABOVE RESIDENT'S ACCOUNT IN FULL, ON A MONTHLY BASIS, WITH MY CREDIT CARD. I AM RESPONSIBLE FOR ALL PAYMENTS. IF PAYMENT IS NOT MADE WITHIN 60 DAYS OF STATEMENT DATE GREAT NECK CHEMISTS INC OF NY CAN REFUSE SERVICE TO THE ABOVE RESIDENT. IT IS MY RESPONSIBILTY TO UPDATE MY CREDIT CARD INFORMATION WHEN NECESSARY.

______________________________________ **Date:** ______________________

(Guarantor / Credit Card Holder)