

RESIDENT ENROLLMENT FORM

PAYMENT INFORMATION

A valid credit card is required to be kept on file to secure this account.

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|------------------------|---|------------|------------------|----------|
| TYPE OF CARD (circle): | VISA | MASTERCARD | AMERICAN EXPRESS | DISCOVER |
| NAME ON CARD _____ | CARD NUMBER _____ | | | |
| BILLING ADDRESS _____ | EXPIRATION (MMYY) ____/____ | | | |
| _____ | SECURITY CODE _____ | | | |
| | *VISA/MC/DISCOVER: 3 digits on back of card | | | |
| | *AMEX: 4 digits on front of card | | | |

Please select an option below and sign.

- I wish to pay automatically by credit card each month – please enroll me in auto-pay.*
- I will mail in payment by check or call to pay by phone each month, promptly after receipt of Guardian’s statement.*

*If payment is not received from resident within 60 days, Guardian Pharmacy will attempt to contact the responsible party. After which, if payment still has not been received, payment will be drafted from card on file. Credit card will only be used after Guardian notifies responsible party of non-payment of an outstanding balance. Guardian reserves the right to withhold services if payment is 90 days or more past due and no good faith effort has been made to bring the balance current. Payments that remain delinquent may be turned over to collections and reported to credit reporting agencies.

RESIDENT OR RESPONSIBLE PARTY SIGNATURE _____