Jackson Pharmacy Solutions
Recurring Credit Card Payment Authorization

- I ______________________________authorize Jackson Pharmacy Solutions to store my card on file, and charge my card for Pharmacy Prescription Copays, not to exceed a total value of $100.00 per order.
- A receipt for each transaction will be provided. The charge will appear on your card statement as **Jackson Specialty Miami**.
- I agree no prior-notification will be required unless the amount exceeds a total value of $100.00.

Cardholder name (as shown on card): ____

Patient name (if different from cardholder): ____

Credit Card Number: ____

Credit card type: ☐ MasterCard ☐ Discover ☐ Visa ☐ AMEX ☐ FSA/HSA

Expiration Date (MM/YY):_______________ CVV: _______________

Cardholder zip code: ____________________

If card is declined, it could delay delivery of your medication. As long as the transactions correspond to the terms and conditions indicated in this authorization, I shall not raise disputes against the Company.
I understand I may cancel or terminate the authorization at any time by contacting Jackson Pharmacy Solutions Billing.

☐ Email approval

☐ Verbal approval

Effective Date: _______________________

Signature: ____________________________

Today's date: _________________________

Jackson Pharmacy Solutions Billing 305-355-5801 or JHSPharmacybilling@jhsmiami.org

Miracles made daily.