CREDIT CARD AUTHORIZATION FORM

The company is pleased to service your healthcare needs. To allow your credit card to be retained on file by your pharmacy, please complete and sign this Credit Card Authorization Form. If you have questions about charges to your account, please contact your pharmacy.

CUSTOMER INFORMATION

FIRST NAME	LAST NAME	BIRTH DATE
_____	_____	____/____/_____
ADDRESS		PHONE #
_____		_____
ADDRESS		
_____		
CITY	STATE	ZIP
_____	_____	_____

CREDIT ON FILE PAYMENT METHOD

You may elect to have your credit card on file with Albertson's by completing the information below. Credit card charges are processed at the time of service. I agree to notify Albertson's of **any** credit card changes, i.e. lost, stolen, or new cards and expiration date changes.

Check Card Type: [ ] Visa [ ] MasterCard [ ] Discover [ ] American Express Account No. _____ Exp. Date _____

Signature of Cardholder **X** _____ Date _____

Internal Use Only
Store # _____

Cardholder Agreement Terms

By signing this Credit Card Authorization Form, I agree to be financially responsible for the payment of all prescription and other medications, supplies, and pharmacy service fees including, but not limited to, delivery and administrative fees provided to the Customer. I agree to provide Albertson's with any and all current information regarding prescription insurance coverage or medical assistance programs under which the Customer is eligible. If the Customer's insurance company or medical assistance program does not pay the entire balance of an item, the balance due will be charged to this account. I agree to allow Albertson's to retain a copy of my credit card on file.