



OC Pharmacy  
31654 Rancho Viejo Rd. Unit N  
San Juan Capistrano, CA 92675

## Card On-File Authorization Form

### Patient(s):

\_\_\_\_\_ ( ) \_\_\_\_\_  
LAST NAME FIRST PHONE

**Name on Card** (exactly as it appears on card): \_\_\_\_\_

### Billing Address:

\_\_\_\_\_ STREET ADDRESS CITY STATE ZIP

PLEASE SELECT CARD TYPE:

VISA     MASTERCARD     AMEX     DISCOVER

<sup>±</sup>ACCOUNT #/CREDIT CARD # : \_\_\_\_\_

EXPIRATION DATE: \_\_\_\_ / \_\_\_\_  
(MM / YY)

### VISA/MASTERCARD

### AMEX

### DISCOVER

CVV2/VCODE: \_\_\_\_\_

SECURITY #: \_\_\_\_\_

CVV2/VCODE: \_\_\_\_\_

THIS NUMBER IS A 3 DIGIT SECURITY  
NUMBER FOUND ON THE BACK-RIGHT OF  
THE CARD

THIS NUMBER IS A 4 DIGIT SECURITY  
CODE FOUND ON THE TOP RIGHT OF  
THE FRONT OF THE CARD

THIS NUMBER IS A 3 DIGIT SECURITY  
NUMBER FOUND ON THE BACK-RIGHT  
OF THE CARD

Special Req: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I have read, completed, and understand the above agreement. I agree to have my card on-file at OC Pharmacy™. I approve of all charges for services rendered by OC Pharmacy™, and I agree to these terms and charges. **All charges are final. OC Pharmacy™ does not accept returns.**

<sup>±</sup> A \$1.00 charge will be made to your card and subsequently refunded if your card is valid and working.

\_\_\_\_\_  
CARD-HOLDER SIGNATURE

\_\_\_\_\_  
DATE