JB Pharmacy Recurring ACH Payment Authorization

I authorize regularly scheduled checking/savings account charges. The amount charged will be the amount on the monthly pharmacy billing statement. A receipt for each payment will be provided and the charge will appear on your bank statement as an "ACH Debit".

I _____ authorize _____ to charge my
(Full Name) (JB Pharmacy)

bank account indicated below for amount due on each monthly itemized statement on or around the 1st of each month for prescription services rendered.

Billing Information

Billing Address _____ Phone # _____

City, State, Zip _____ Email _____

Bank Details

☐Checking ☐ Savings

Account Name _____
Bank Name _____
Account Number _____
Routing Number _____

I understand that this authorization will remain in effect until I cancel it, and I agree to notify JB Pharmacy of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. In the case of an ACH Transaction being rejected for Non-Sufficient Funds (NSF) I understand that JB Pharmacy may at its discretion attempt to reprocess the charge again within 30 days. I agree to an additional bank fee for each attempt returned as NSF. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law.

SIGNATURE _____ DATE _____
(Account Holder's Signature)

ASSISTED LIVING RESIDENT NAME:_____

ASSISTED LIVING FACILITY NAME:_____

Completed form may be sent to pharmacy by:
Email: jbpharmacyinfo@gmail.com
Faxed: (401) 383-7773
Mailed: 1165 Main Avenue, Warwick, RI 02886