Astor Drugs

Payment Authorization form

Business Name: _____ Business Phone:_____

Email:_____ Customer Number:_____ Date: _____

Payment Options (check appropriate box - required)

☐ **Current Transaction:** ____This authorization is valid for this transaction. The transaction amount will be

$ _____ (transaction amount required).

☐ **Open Authorization**: Due on the net terms assigned.
Open authorization to allow debits to my account for amount(s) which will vary per transaction(s).

☐ **Pre-Pay:** Due at the time of invoicing. This is an open authorization to allow debits to my account for amount(s) which will vary per transaction(s).

Select the Preferred Payment Method (required)

☐ **ACH Draft - No fee** (must submit a voided check with this form) ☐

I _____ authorize Astor Pharmaceuticals LLC to debit the bank account indicated below for payment of my obligations.

Bank: _____ Bank Address: _____

Account Information (required) Account #_____ ABA Routing #_____

Name on Account: _____

Billing Address: _____

Credit Card

☐

Card Number: _____ CVV Code Required: _____ Expiration Date (mm/yy): _____

I hereby authorize Astor Pharmaceuticals LLC charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

Name on Card and Account: _____

Billing Address: _____

I have read and agree to all the terms and conditions on this page and any other contract or document that accompanies this agreement. I certify that I am the authorized account holder for this account. I understand this is a binding agreement.

Terms and Conditions: If the payment due date falls on a weekend or holiday, I understand and agree that the payment may be executed on the next business day. I understand and agree that as this is an electronic transaction, adequate funds must be available for withdrawal from my account by the payment due date. I understand and agree that the company may at its discretion resubmit the debit transaction within thirty (30) days.

I understand that all returned ACH debits are subject to a $50.00 NSF Fee, in addition to the original amount to be paid. This agreement will remain in effect until Astor Pharmaceutcials LLC receives my written notice of cancellation via mail, fax, or email.

_____ _____

Authorized Signature (required) Date (required)

FORM MUST BE FAXED (631) 381-6225 or emailed to info@astordrugs.com

Astor Pharmaceuticals LLC
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