



## One Time Payment Authorization Form

**Please complete the information below:**

I \_\_\_\_\_ authorize Gulf Coast Pharmaceuticals Plus, LLC to initiate a  
**ONE TIME** ACH debit Charge as indicated below.

Business Name: \_\_\_\_\_

Billing Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone#: \_\_\_\_\_ Email: \_\_\_\_\_

Invoice #(s): \_\_\_\_\_

Total amount: \_\_\_\_\_

### ACH Checking/ Savings Account

Checking       Savings

Name on Acct \_\_\_\_\_

Bank Name \_\_\_\_\_

Account Number \_\_\_\_\_

Bank Routing # \_\_\_\_\_

Bank City/State \_\_\_\_\_



Sales Representative: \_\_\_\_\_

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Gulf Coast Pharmaceuticals Plus, LLC in writing 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. For ACH debits to my checking/savings account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Non Sufficient Funds (NSF) I understand that Gulf Coast Pharmaceuticals Plus, LLC may at its discretion attempt to process the charge again within 30 days, and agree to an additional charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank or credit card company so long as the transactions correspond to the terms indicated in this authorization form.