995 N. Halstead Road
Ocean Springs, MS 39564
888-574-7366

One Time Payment Authorization Form

Please complete the information below:

I ____________________________ authorize Gulf Coast Pharmaceuticals Plus, LLC to initiate a

ONE TIME Credit Card Charge as indicated below.

Business Name:____

Billing Address: ____

City, State, Zip: ____

Phone#: __________________________ Email: ____

Invoice #(s) : ____

Total Amount to charge: _________________

Credit Card Authorization

VISA	AMEX	MasterCard	Discover

Cardholder Name: ____

Business Name: ____

Card Number: ____

Expiration date: __________________________ Security Code: _____________________________

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. 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.