HO-CHUNK NATION
DEPARTMENT OF HEALTH
Pharmacy Division

Credit Card Authorization Form

Please completely fill out the credit card authorization form and return to Ho-Chunk Health Care Center Pharmacy. Payment is for Co-pays, co-insurance, non-covered services, and deductibles that are due at the time of dispensing medications.

All information will remain confidential.

Patient Name: _____

Cardholder Name: _____

Billing Address: _____

City: _____ State:_____ Zip Code: _____

Phone # (*optional – if we have questions for you*):_____

Email: (*optional – if you want a receipt emailed to you*)_____

Credit Card Type: ( )Visa ( )MasterCard ( )Discover ( )AmEx

Credit Card Number: _____ Exp. Date: _____

____ One Time Use (Amount to Charge: $_____)

-OR-

____ Permanent File (Recurring Charges)

Cardholder-Print Name, Sign and Date below:

Signed:_____Date:_____

Print Name:_____

I authorize Ho-Chunk Health Care Center Pharmacy to charge the agreed amount listed above to my credit card provided herein. I agree that I will pay for this purchase in accordance with the issuing bank cardholder agreement If you wish to remove your credit card information from our system, please notify us immediately.

For office Use Only
One Time CC Auth
Initials_____
Date_____

Ho-Chunk Health Care Center
N6520 Lumberjack Guy Road
Black River Falls, WI 54615
Ph. 715-284-9851 FAX 715-284-2293

House of Wellness
S2845 White Eagle Rd
Baraboo, WI 53913
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