Pittwater Pharmacy
& Compounding Chemist

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Pharmacy Account Application Form

1. CLIENT: **First Name** **Last Name** **OR**	First Last	Date of Birth (n/a for Business)	
2. Aged Care Facility **OR** **Business Name**	Respite?(For aged care facilities) Yes No	GP (Community Doctors only)	

Person Responsible for Paying Account	
Name	
Address OR Business Address	
Home phone:	
Mobile:	
Email address for account	
Drivers license:	

********************PLEASE NOTE*********************

##########CREDIT/DEBIT CARD AUTHORISATION (Required by all applicants)##########

IMPORTANT: This section must be completed by all applicants for security purposes only, this card will not be charged unless this method of payment is chosen below in "Payment Terms"

Name as it appears on card:				
Card type (circle):	VISA	MasterCard	AMEX	
Card number:				
Expiry Date:				

PAYMENT TERMS:

Please choose a payment method from the selection below (please tick):

Cash or Cheque*	Electronic funds transfer*: BSB: 032-196 Acct #: 209071	Automatic monthly credit/debit card charge**
☐	☐	☐

*If you choose either of these payments and we receive no payments within 45 days of the first account statement, we reserve the right to charge the above credit card for the entire amount owing on the account
**If you choose for us to charge your credit card monthly it will be debited within one week of the end of month. Your account statement will still be emailed or posted to you.

SIGNED:		**DATE:**	

By signing this form you agree to Pittwater Pharmacy supplying and billing medications for the above client and accept all payment terms.

FOR YOUR INFORMATION: PITTWATER PHARMACY IS OBLIGED UNDER CONTRACT TO SUPPLY MEDICATIONS THAT HAVE BEEN ORDERED BY THE VISITING MEDICAL DOCTOR TO RESIDENTS OF THIS FACILITY. RESIDENTS/NEXT OF KIN MAY RECEIVE A MONTHLY ACCOUNT STATEMENT WHICH SHOULD BE SETTLED BY THE END OF THE FOLLOWING MONTH.