



PHARMACY CHARGE ACCOUNT AGREEMENT

Stephens Pharmacy / Northeast Med-Equip provides charge accounts as a convenience to qualified customers and reserves the right to discontinue the charge account program at any time. Credit privileges are extended based on prior credit approval.

If approved, customer agrees that credit is extended subject to the following terms and conditions:

1. Payment on account is due upon receipt of invoice which is defined to be the 20th day of the month following statement date. It is further understood that to maintain charging privileges, the account must remain current. Past-due accounts will not be eligible for delivery services.
2. Customer personally guarantees the financial obligations resulting from such charge account and agrees to pay invoices per the terms outlined above. In the event that the account becomes past-due any monies owed will incur interest charges at the rate of 1.5 percent (1.5%) per month. In the event that legal counsel is required to assist in the collection process, additional fees may apply.
3. Customer agrees that jurisdiction for any such credit action shall be Wayne County, PA. In the event of a conflict, the laws of the Commonwealth of Pennsylvania shall apply.
4. Stephens Pharmacy is authorized to terminate its charge account program at anytime at its sole discretion.
5. Customer authorizes any holder of medical information to release to the insurance carrier or any agency or representative of said insurance company for the purpose of obtaining payment for services provided to customer.
6. I understand that by signing this agreement, I authorize provision of products or services or both from the company and/or its affiliates and I have been given an opportunity to review the Notice of Privacy Practices for Protected Health Information of Stephens Pharmacy.

SIGNED: _____ DATE: _____

PRINTED NAME: _____

CREDIT APPLICATION AND PAYMENT

You may elect to make payment via credit or debit card or via checking account debit. Simply supply the information requested and we will automatically charge your account each month and mail you a copy of the charge receipt.

If by Bank Draft:

Bank Name Routing Number Checking Account Number

If by Credit Card:

Credit Card Number Type Exp. Date

Customer / RESPONSIBLE PARTY BILLING INFORMATION:

Customer Name: _____

Social Security #: _____ Birth Date: _____

Address: _____

City: _____ State: _____

Responsible Party Name : _____

Contact Home Phone: _____ Mobile : _____

Email Address: _____

(only used to communicate with you. Will not be shared.)

The applicant authorizes Stephens Pharmacy to make all inquiries necessary to determine applicant's credit. The application indemnifies the Company and its agents from any liability resulting from their credit inquiry.

SIGNED: _____ DATE: _____

PRINTED NAME: _____