UNIVERSAL ARTS
COMPOUNDING PHARMACY
Specialty & Sterile Medications • Clinical Trials

PCAB ACCREDITED
Compounding Pharmacy

Automatic Refill Authorization Form

To set up an automatic refill for your medications, a credit card authorization must be filled out, signed and returned to us. Payment for your medications will be obtained from your credit card as noted below. Any changes to credit card or shipping address must be notified to us within 4-5 days prior to the automatic refill to ensure order will be charged to correct credit card and shipped to correct address. Please complete this form and return to **Universal Arts Pharmacy, Inc.** via fax 305-556-9749, by email to prescriptions@uaprx.com or frontdesk@uaprx.com or to our address below.

(Please check off the options of current and/or future charges)

I, _____ (print name of card holder), hereby authorize all

☐ Current and/or ☐ Future charges for refills to be collected by Universal Arts Compounding Pharmacy as identified by the original prescription on file. Refills will be automatically processed according to the doctor's intended days' supply of medication. Each refill will be charged to my credit card (which is identified below or any other credit card given to the pharmacy by the customer) at the time it will be processed. In the event of a cancellation of a refill dispensing, I will contact the pharmacy 4-5 days prior to the refill coming due.

Signature of Cardholder X_____ Date: _____

Credit Card Account to Charge:

____Master Card ____Visa ____American Express ____Discover Card

Card Number _____

Exp. Date: _____/_____/_____ Security Code: _____

Name on Card _____

Mailing Address on Card: _____

_____

Contact Phone Number or Email: _____

If available, please state all Rx numbers to fill automatically:

_____

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