IMPORTANT PAYMENT INFORMATION

PAYMENT OPTIONS:

Cheque: You can send in a cheque by mail and make cheques payable to "**MediSystem Pharmacy**". Please make sure to write the resident's account number on each cheque when making payments.

In-Branch/Internet Banking: Payments can be set up at your bank, or through online banking. The payee name would be **MEDISYSTEM PHARMACY ALBERTA.**

Payment by Credit Card: For one-time credit card payments, please contact MediSystem Pharmacy Accounts Receivable Department Toll Free at 1-833-633-4797.

Pre-Authorized Credit Card: Please contact MediSystem Pharmacy Accounts Receivable Department Toll Free at 1-833-633-4797.

Pre-Authorized Debit: Please complete and return this page with a **VOID CHEQUE** to the following address or fax the completed form to Accounting at 416-443- 6234.
Please do not send cash by mail to pay for your invoice.

MediSystem Pharmacy
243 Consumers Road, Toronto, Ontario, M2J 4W8

I hereby authorize **MediSystem Pharmacy** (hereinafter called the **Payee**) to debit the bank account for which I have attached a void cheque for the variable amounts owing for the personal goods and services provided by the Payee. The debit will occur on or before the 27th day of every month.

I understand that I may cancel my authorization at any time by providing written or verbal notice to the payee within 15 days of the next scheduled debit. I may obtain a sample cancellation form or further information on my right to cancel this pre-authorized debit agreement at my financial institution or by visiting www.cdnpay.ca. I have certain recourse rights if any debit does not comply with this agreement. For example, I have the right to receive reimbursement for any debit that is not authorized or is not consistent with this pre-authorized debit agreement. To obtain more information on my recourse rights, I may contact my financial institution or visit www.payments.ca.

AUTHORIZED SIGNATURE:_____ ☐ Resident ☐ Power of Attorney

RESIDENT/POWER OF ATTORNEY NAME (please print): _____

RESIDENT NAME:_____ FACILITY NAME: _____

DATE (dd-mm-yyyy): _____

Please retain your monthly Statement/Invoice as this contains a record of all medications supplied by the pharmacy. MediSystem Pharmacy does not issue an end-of-year prescription summary. However, we can provide you with a reprinted Statement/Invoice that lists all the medication charges and payments applied for the tax year, if required.