MediSystem Pharmacy
A SHOPPERS DRUG MART COMPANY

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: Once you receive your first statement, this can be set up with your bank so that payments are made to the payee, MediSystem Pharmacy Alberta. Internet payments should be made to MEDISYSTEM PHARMACY ALBERTA.

Payment by Credit Card: Please contact MediSystem Pharmacy's Accounts Receivable Department at Toll Free 1-866-900-6900.

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 Limited
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.