E-Cheque Payment **Service**

Pre-Authorized Check/Debit Agreement

ADVCARE® PHARMACY

1. Payor's Name and Address - please print

I/We warrant and represent that the following information is accurate.

Fillable Form

Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐	Surname	First Name
Street		
Town	ZIP	Phone No.

Name of Payor's Financial Institution (the "Processing Institution")		
Street		
Town	ZIP	Account No.

I/We have attached a sample check marked "VOID" to this payor authorization (the "Authorization").

I/We will inform the Payee, in writing, of any change in the information provided in this section of the Authorization prior to the next due date of the PAD (Pre-Authorized Debit).

2. Payee's Name and Address

Name of Payee (the "Payee")	ADV-Care Pharmacy Inc.	
Street	195 Riviera Dr. Unit 2	
Town Markham	Postal Code L3R 5J6	Phone No. (905) 948 - 1991

3. I/We acknowledge that the Authorization is provided for the benefit of the Payee and the Processing Institution and is provided in consideration of the Processing Institution agreeing to process debits against my/our account, as listed above, (the "Account") in accordance with the Rules of the Canadian Payments Association.

4. I/We warrant and guarantee that all persons whose signatures are required to authorize withdrawals from the Account have signed the Authorization below.

5. I/We hereby authorize the Payee to issue Pre-Authorized Debits (as defined in Rule H1 of the Rules of the Canadian Payments Association) (the "PAD") drawn on the Account, for the following purpose:

☐ PERSONAL MEDICATION PURCHASE OR ☐ BUSINESS USE

6. I/We may cancel the Authorization at any time upon providing written notice to the Payee not to exceed 30 days, to obtain sample of cancelation form or to obtain more information visit www.cdnpay.ca .
7. I/We acknowledge that provision and delivery of the Authorization to the Payee constitutes delivery by me/us to the Processing Institution. Any delivery of the Authorization to the Payee, regardless of the method of delivery, constitutes delivery by me/us.

Fax to: 905-948-0464

ADV-CARE Pharmacy
195 Riviera Dr. Unit 2
Markham, Ont. L3R 5J6
Telephone: (905) 948-1991
Toll-Free: (888) 471-4721
Fax: (877) 948-0464

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8. The Payee will provide to me/us, at the address provided in Section 1:
   (a) with respect to fixed amount PADs, written notice of the amount to be debited (the "Payment Amount") and the date(s) on which the Payment Amount debited will be posted to my/our Account (the "Payment Date"), at least 10 calendar days before the Payment Date of the **first** PAD, and such notice shall be provided every time there is a change in the Payment Amount or the Payment Date(s);
   (b) with respect to variable amount PADs, written notice of the Payment Amount and the Payment Date(s), at least 10 calendar days before the Payment Date of **every** PAD; and
   (c) with respect to a PAD plan that provides for the issuance of a PAD in response to a direct action of mine/ours (such as, but not limited to, a telephone instruction) requesting the Payee to issue a Pad in full or partial payment of a billing received by me/us for a payment obligation that meets the requirements of Section 2 or Rule H1, no notice is required.

9. The Payee may issue a PAD _____ in a dollar amount up to a maximum of $_____.
   (insert frequency of debits)
   (If you will be using the check/debit only once, enter 1 for the frequency and the $ amount owing. If you are planning on using the check/debit for future purchases, then leave the space blank.)

10. I/We acknowledge that the Processing Institution is not required to verify that a PAD has been issued in accordance with the particulars of the Authorization including, but not limited to, the amount, or that any purpose of payment for which the PAD was issued has been fulfilled by the Payee as a condition to honouring a PAD issued or caused to be issued by the Payee on the Account.

11. Revocation of the Authorization does not terminate any contract for goods or services that exists between me/us and the Payee. The Authorization applies only to the method of payment and does not otherwise have any bearing on the contract for goods or services exchanged.

12. I/We may dispute a PAD only under the following conditions:
   (i) the PAD was not drawn in accordance with the Authorization;
   (ii) the Authorization was revoked; or
   (iii) pre-notification, as required under Section 8 was not received.

   I/We acknowledge that in order to be reimbursed a declaration to the effect that either (i), (ii) or (iii) took place, must be completed and presented to the branch of the Processing Institution holding the Account up to and including 90 calendar days after the date on which the PAD in dispute was posted to the Account.
   I/We have certain recourse right if any debit does not comply with this agreement. For example, I/We have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD Agreement. To obtain sample of cancelation form or to obtain more information visit www.cdnpay.ca
   I/We acknowledge that when disputing any PAD beyond the time allowed in this section, it is a matter to be resolved solely between me/us and the Payee, outside the payments system.

13. I/We understand and accept the terms of participating in this PAD plan.

_____ _____
(Authorized Signature) (Date)

_____
(Client Name in full)

N.B. Include a void check with your paperwork.

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Credit Card Payment

Pre-Authorized Credit Card Agreement

If you want to paying by credit card, complete fillable form, sign it and send it by fax to us.

Credit Card Information				
Credit Type: ◯ Visa ◯ Master Card				
Name as it appears on card:	**Card number:**	**Date of Expiry**		**CVD**
		MM	YYYY	
Authorization: I authorize ADV-Care pharmacy or its affilited company to charge my credit card.				
Signature of cardholder:		**Date:**		
		Year	Month	Day

(CVD) 3 Digit Card Verification Number

(CVD) 4 Digit Card Verification Number

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