

H O T Z E

P H A R M A C Y™

AUTO FILL SIGN-UP REQUEST

Name: _____

Shipping Address: _____

City: _____ State: _____ Zip: _____

Best Contact Number: _____

Email Address: _____

.....
 Disc VISA MC AMEX Number _____

Exp _____ CVV _____ Cardholder _____

Prescriptions to be Auto Filled: _____ Quantity: _____

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10. _____

I prefer to: pick up my prescription(s) have my prescription(s) shipped

Signature: _____ Date: _____

I understand the prescriptions above will be automatically filled, charged to the above credit card and shipped to the above address on the designated filling date. I will notify Hotze Pharmacy of any changes to my prescriptions, credit card, and/or address.

Please fill out this form and return it to Hotze Pharmacy via email, mail or fax.

20214 Braidwood Drive, Suite 140, Houston, Texas 77450
pharmacy@hotzepharmacy.com fax: (281) 828-9669

