Pre-Authorized Debit Request Form

RESIDENT NAME: _____

FACILITY NAME: _____

DATE (DD-MM-YYYY): _____

Pre-Authorized Debit: Complete and return this page with a **VOID CHEQUE or Pre-Authorized Debit Form** to the following address or fax the completed form to accounting at 416-443- 6234.

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

NAME OF SIGNEE (PLEASE PRINT): _____

Affix Copy of Void Cheque in this section or
Include a Direct Deposit Form to this form

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.

Updated: October 2025