LAUREL PET HOSPITAL

Credit Card Authorization

INTERNAL USE ONLY
Account Number:

Date:

Thank you for choosing Laurel Pet Hospital.

Pet Owner's Name:

Card Holder Name: _

Card Number: _

Expiration Date: _ _ _ _ _ _ _ _ _ _ _ _ _ _ CVV Code: _ _ _ _ _ _ _ _ _ _ _ _ Card Type: _ _ _ _ _ _ _ _ _ _

Billing Address: _

City: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ State: _ _ _ _ _ _ _ _ _ _ Zip Code: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

PLEASE INITIAL ONE:

_ _ _ _ _ I Authorize Laurel Pet Hospital to charge my credit / debit card for veterinary services on ____________________________. (one time use only)

_ _ _ _ _ I Authorize Laurel Pet Hospital to keep my card number on file for future use.

CCR Initials: ___________ Date: ______________

AUTHORIZATION FOR PAYMENT OF MEDICAL TREATMENT

I assume financial responsibility for all charges incurred to the patient and consent to the reals of medical information to the above name family veterinarian. I understand the clinic and its personnel does not give any guarantee that the recommended treatments/procedures will correct or cure the conditions for which my pet was presented. I understand that if my credit or debit card is returned unpaid for any reason that will be subject to additional charges and that if a collection agency/attorney must be used to collect the balance of the charges resulting from care received by my pet at Laurel Pet Hospital, I will be responsible for paying any collection cost/fees.

Client or Auth Agent Signature

Date