



## Credit Card Payment Authorization

Owner's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zipcode: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Is your Billing Address the Same As Above? Yes No

If No, enter billing address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zipcode: \_\_\_\_\_

The below credit card information will be kept on file at McGee Equine Veterinary Clinic. This credit card information will be used to pay the entire invoice at the time of service, or at the time of billing, to pay in full, any outstanding balance on my account. I hereby authorize McGee Equine Clinic to utilize my credit card for payment as detailed above.

I understand that I am financially responsible for all services provided by McGee Equine Veterinary Clinic. I agree for McGee Equine Clinic to hold in their possession a copy of a current credit card to apply payment in full to the balance due on the account. In the unlikely event that the credit card will become declined, action will be taken for collection for balance due on account at such time credit card is declined.

### Credit Card Information:

Circle: VISA MasterCard Discover AmEx Other: \_\_\_\_\_

Account Number: \_\_\_\_\_

Expiration: \_\_\_\_\_ CCV: \_\_\_\_\_ Zipcode: \_\_\_\_\_

### Billing Information (If different from above)

Name on Card: \_\_\_\_\_ Phone: \_\_\_\_\_

Billing Address for card: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zipcode: \_\_\_\_\_ Email: \_\_\_\_\_

I understand if these credit card payments go over 30 days, that each monthly statement that is sent to me will be subject to a \$15.00 billing fee. I understand that a late fee of 1.5% per month or 18% annually will be applied to all accounts more than 30 days past due. I further understand that as the Owner I am responsible for all court costs and lawyer fees if account is turned over to collection.

Authorized Signature: \_\_\_\_\_

Print Authorized Signature: \_\_\_\_\_