

OKLAHOMA CITY EQUINE CLINIC, P.C.



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Credit Card Payment Authorization Form

Credit Card Information:

____ Visa ____ MasterCard ____ Discover ____ AmEx ____ Care Credit

Credit Card Number: _____

Expiration: ____/____ Security Code: _____ Billing Zip Code: _____

Cardholder Information:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

H: _____ C: _____ Other: _____

Terms: *(Please indicate preferences by marking with an X to all that apply)*

- Please charge my credit card for my **current balance** in the amount of _____.
- Please charge future invoices once at the **end of each month** for all services incurred.

I authorize *Oklahoma City Equine Clinic, P.C.* to charge the above credit card for payment of services rendered.

Signature: _____ **Date:** _____

For office use only:

Form received: On _____ By _____

Voice authorization: On _____ By _____