## **Credit Card Authorization Form**

All information will remain confidential.

First: M: Last:  Billing Address:  City: State: Zip:  Phone: Email:  Patient Information  Name: Species: Breed:  Credit Card Information  Visa Mastercard Discover  Care Credit (6 month payment plan)  Credit Card Number: Expiration Date:  Card Identification Number (last 3 digits located on the back of the credit card):  Amount:  I authorize Veterinary Emergency and Critical Care to charge the agreed amount listed above to my credit card provided herein. I understand that the above amount will be posted to the aforementioned credit card upon receipt of this authorization. Any additional charges/amounts must be approved by me and only me prior to the posting of said charges.  In addition to this written authorization letter, a legible copy of my credit card both front and back and my state driver's license must be attached, transmitted via facsimile with this authorization to 702-262-7099, or emailed to forms@vecc24.com.  Cardholder Signature: Date:  Print Name:	Cardholder Information					AEL	
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