

# Credit Card Authorization Form

All information will remain confidential.



## Cardholder Information

First:	M:	Last:
Billing Address:		
City:	State:	Zip:
Phone:	Email:	

## Patient Information

Name:	Species:	Breed:
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## Credit Card Information

Visa	Mastercard	Discover	
Care Credit ( <b>6 month payment plan</b> )			
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](mailto:forms@vecc24.com).

Cardholder Signature:	Date:
Print Name:	

## Office Use

VECC Staff Initials:                      Notes: