Credit Card Authorizaton

Accepted Credit Cards: Visa®, MasterCard®, Discover®, or American Express®

Credit Card Information

PRIMARY CARD:

Name as it appears on the card: _____

Card #: _____

Exp Date: _____ Security Code: _____ Type of Card: _____ Billing Zip Code: _____

SECONDARY CARD (optional):

Name as it appears on the card:_____

Card#: _____

Exp. Date: _____Security Code:_____Type of Card: _____Billing Zip Code:_____

Contact Information (all fields required)

Name: _____

Phone Number: _____ Email: _____

By providing the above information you are authorizing PEH to charge medications, treatments, laboratory services, and all other necessary veterinary services, to your credit card at the following times:
(Please check all that apply)

One time_____*Daily_____ *Weekly:_____*Monthly (per statement):_____

Special Instructions:_____

Dates charges may occur: ____/____/_____ to ____/_____/_____
M D Year M D Year

_____ _____
Card Holder Signature Date

***Please note that if you are making daily, weekly, or monthly payments, your credit card will be added to our secure system and there will be a one time $0.50 verification fee taken out on your card. That fee is then reimbursed when your first payment is ran through the secure system.**

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