Credit Card Authorization

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

Credit Card Information

PRIMARY CARD (required):

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 (autopay stmt): _☐_

*Monthly (authorization required per stmt): _☐_

Special Instructions: _____

- **You may cancel your autopay transactions at any time by contacting us.**
- **This authorization will remain on file until the above credit card expires.**

_____ _____
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 $1.00 hold placed on your account, which is refunded within 7-10 business days.**

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