OKLAHOMA CITY EQUINE CLINIC, P.C.

400 NE 70th St.
Oklahoma City, OK 73105
(405) 843-1099
Fax: (405) 843-1143
Email: info@oklahomacityequine.com
www.oklahomacityequine.com

Brian S. Carroll, DVM
Dee M. Gragg, DVM
Larry D. Powers, DVM
Jason Miles, DVM
Emily Hood, DVM

Credit Card Payment Authorization Form

Credit Card Information:

____ Visa ____ MasterCard ____ Discover ____ AmEx

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.
- ☐ Please charge future invoices to my credit card **as services** are provided and invoices generated.
- ☐ Please send copies of my invoice(s) and credit card receipt(s) via mail as they are generated.
- ☐ I receive and only require monthly statements from my credit card company, thus, it is not necessary to send credit card receipts.
- ☐ Please call me before charging my card when the amount is over $_____.
- ☐ Payment plan agreement: Charge my credit card $_____ each month on the _____ of each month beginning _____ until paid in full.

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 _____