

# OKLAHOMA CITY EQUINE CLINIC, P.C.



400 NE 70<sup>th</sup> St.  
Oklahoma City, OK 73105  
(405) 843-1099  
Fax: (405) 843-1143  
Email: [info@oklahomacityequine.com](mailto:info@oklahomacityequine.com)  
[www.oklahomacityequine.com](http://www.oklahomacityequine.com)

Brian Carroll, DVM  
Dee Gragg, DVM  
Amanda Willis, DVM  
Connie Finley, DVM, DACVS-LA  
Sarah Heenan, DVM

## Credit Card Payment Authorization Form

### Credit Card Information:

\_\_\_\_ Visa    \_\_\_\_ MasterCard    \_\_\_\_ Discover    \_\_\_\_ AmEx    \_\_\_\_ Care Credit

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 for future invoices once at the **end of each month** for all services incurred.
- Please call me with total before charging my card. If I am unable to be reached, my card will be charged at the end of the month.

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 \_\_\_\_\_