



CREDIT CARD AUTHORIZATION FORM

PLEASE COMPLETE THIS AUTHORIZATION AND BRING IT TO YOUR NEXT VISIT OR RETURN IT TO OUR OFFICE BY FAX: (212) 288-9432 OR EMAIL: INFO@UNIVERSITYANIMALHOSPITAL.COM

Name: _____ Patient's Name: _____

Cardholder Name: _____

Signature: _____

Billing Address: _____

Billing Zip Code: _____

Credit Card Type: _____ VISA _____ MASTERCARD _____ DISCOVER _____ AMEX

Credit Card Number: _____

Expiration Date: _____ / _____

Credit Card Security Code: _____

I authorize University Animal Hospital to store my credit card and to keep this authorization form in my pet's file.

I give permission for all hospital services, boarding/grooming, and products purchased to be charged to the above mentioned card.

Name: _____

Authorized Signature: _____

Date: _____

PLEASE PROVIDE A COPY OF YOUR ID AND A COPY OF THIS CREDIT CARD (BOTH FRONT AND BACK)