



Credit Card Authorization Form
Please complete ALL fields

I, _____ (please print full legal name), authorize Turtle Valley Equine Hospital to charge my credit card for current and future payments to balance(s) on my account # _____.

Credit Card Type (circle one):

MasterCard Visa Discover AMEX CareCredit

Cardholder Name, as shown on card: _____

Card Number: _____ - _____ - _____ - _____

Expiration Date (MM/YY): ____ / ____

Security Code on back of card: _____

Credit Card Billing Address:

Street Address: _____

City: _____ State: _____ ZIP: _____

Phone Number on Credit Card Billing Account: _____ - _____ - _____

Cardholder- Printed Name

Driver's License or Gov ID Number

Cardholder- Signature

State or Gov Authority issuing above ID

Date

ID Expiration Date