Credit Card Authorization Form

All information will remain confidential.

Cardholder Information			
First:	M:	Last:	
Billing Address:			
City:	State:	Zip:	
Phone:	Email:		
Patient Information			
Name:	Species:	Breed:	
Credit Card Information			
Visa	Mastercard	Discover	
Care Credit **(6 month payment plan)**			
Credit Card Number:	Expiration Date:		
Card Identification Number (last 3 digits located on the back of the credit card):			
Amount:			
Department			
Cardiology	Internal Medicine	Oncology	
Ophthalmology	Rehabilitation	Surgery	

I authorize Las Vegas Veterinary Specialty Center to charge the agreed amount listed above to my credit card provided herein. I understand that the above amount will be posted to the aforementioned credit card upon receipt of this authorization. Any additional charges/amounts must be approved by me and only me prior to the posting of said charges.
In addition to this written authorization letter, a legible copy of my credit card both front and back and my state driver's license must be attached, transmitted via facsimile with this authorization to 702-262-7000, or emailed to *forms@lvvsc.com*.

Cardholder Signature:	Date:
Print Name:	

Office Use

LVVSC Staff Initials: Mobile: Procedure: