Thompson & Associates
EQUINE MEDICINE

CREDIT CARD AUTHORIZATION FORM

Cardholder Information

Name: _____

Billing Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone Number(s): _____

Credit Card Information

Name on Card: _____

Credit Card Type (circle one): Visa MasterCard American Express Discover Other: _____

Card Number: _____

Expiration (Month/Year): _____ **CVV:** _____

*By signing below, I authorize **Thompson & Associates Equine Medicine** to charge my credit card for any agreed upon services or purchases. I also understand that my information will be kept on file for future transactions.*

Signature: _____ Date: _____

Print Name: _____