TACOMA EQUINE HOSPITAL
Quality Care. Compassionate People. Exceptional Service.

3112 - 156th Street East
Tacoma, WA 98446
Tel: (253) 535-6999
www.tacomaequine.com

Credit Card Authorization

Name: _____Account Number:_____

Billing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

E-Mail: _____

I authorize Tacoma Equine Hospital, LLC to keep my credit card number on-file and:
(check one)

- ☐ To charge my credit card at the time of service for the total cost of services rendered.
- ☐ To charge my credit card at the time of service for services rendered up to $_____. They are to call me if the total due is over this amount prior to running my credit card.
- ☐ To charge my credit card at the time of statements for the statement total *(requires prior authorization by Tacoma Equine Hospital).*
- ☐ To charge my credit card at the time of statements for the amount up to $_____ *(requires prior authorization by Tacoma Equine Hospital).* They are to call me if the total due is over this amount prior to running my credit card.
- ☐ They are to call me prior to charging my credit card for any services rendered.

Signed: _____ Date: _____

Credit Card Information:

Name on Card: _____

Card Number: _____ CSC: _____

Expiration Date: _____ Visa MasterCard Care Credit Citi Health Card

Billing Address (if different than above): _____

Signed: _____ Date: _____