



Dr. Miranda Noseck, DVM Inc.
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CREDIT CARD AUTHORIZATION

Client Name: _____

Mailing Address: _____

Phone: _____

Horse(s): _____

(PROVIDE NAME, BREED, AGE, SEX, COLOR)

Dr. Miranda Noseck, DVM Inc. requires payment in full at the time services are rendered or medications are dispensed. Some clients are not able to be present when their horse is examined or treated. In this instance, Dr. Miranda Noseck, DVM Inc. requires authorization for credit card payments as well as details of who is able to make decisions regarding the horses on the account.

Please use my credit card for CURRENT VISIT ONLY or ALL VISITS IN THE NEXT YEAR. (CIRCLE ONE)

Please list the names of any individuals authorized to make decisions regarding your horse(s). Please indicate if you would like to be personally contacted prior to any services being provided or decisions made.

How do you prefer to receive your invoice? EMAIL or MAIL (CIRCLE ONE & provide preference below)

Billing address: _____

Email address: _____

Credit card type: VISA or MASTERCARD (CIRCLE) Name on card: _____

Credit card #: _____

Expiration: _____ V-code: _____ (3-digit number on back of card)

By signing below I authorize Dr. Miranda Noseck, DVM Inc. to use my credit card to process all outstanding balances against my account. Accounts will usually be processed within 24 hours of services being rendered. By signing below I confirm that the credit card details provided are for a valid account with sufficient funds for the services rendered. There is a \$25.00 service fee for all declined credit cards and service charges of 2% per month for outstanding accounts. I understand that Dr. Miranda Noseck, DVM Inc. provides emergency service only to current, regular clients whose accounts are in good standing.

I DO or I DO NOT (CIRCLE ONE) need to be contacted prior to completion of each invoice against my account.

Signature: _____ Date: _____