



HEARTLAND EQUINE HOSPITAL

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Payment Authorization

Please choose at least one of the following 3 choices:

New clients are required to leave a deposit and have credit card information upon admittance. Payment in full is required at discharge.

I hereby authorize Heartland Equine Hospital to charge my credit care:

1. _____ Balance in full this visit.
2. _____ Deposit on admission \$ _____ (50% of estimate of services).
3. _____ Call to authorize charging card.

Credit Card Information:

Card Type: _____

Card Number: _____ Security Code: _____

Name on the Card: _____

Expiration Date: _____ Zip Code: _____

Billing Address: _____

Signature: _____ Date: _____

For Office Use Only – Completed By: _____ Date: _____

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