



3625 Pacetti Road, Saint Augustine, FL 32092

Payment Authorization Form

Please complete the information below:

I _____ authorize MuraBella Animal Hospital to charge my credit card, or keep my credit card on file based on the amount authorized by an Owner or Co-Owner, a Caregiver (Caregiver authorization form required) or as agreed on a Promissory Note.

Billing Address _____

Phone# _____

City, State, Zip _____

Email _____

Credit Card

Visa

MasterCard

Amex

Discover

Cardholder Name _____

Account Number _____

Exp. Date _____ CVV _____

If Applicable:

Recurring Payment of: \$_____ until balance of: \$_____ is paid in full.

I understand that this authorization will remain in effect until my balance is paid in full, and I agree to notify **MuraBella Animal Hospital** in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. In the case of a transaction being rejected for Non Sufficient Funds (NSF) I understand that **MuraBella Animal Hospital** may at its discretion attempt to process the charge again within 30 days, and agree to an additional **\$35** charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment.

If Applicable:

I authorize MuraBella Animal Hospital to keep my credit card on file for future use. I understand I will be contacted by phone or email, and my final authorization obtained, for any and all charges associated with this card.

I certify that I am an authorized user of this credit card and will not dispute these scheduled transactions with my bank or credit card company; so long as the transactions correspond to the terms indicated in this authorization form.

Signature: _____

Date: _____

Staff Member Name (Witness): _____ Date: _____