Kinder4Rescue
SURGICAL CENTER

4926 Vineland Ave. North Hollywood 91601
Virtual Reception: (818) 505-0006

PAYMENT AUTHORIZATION FORM

I, _____ (cardholder's name), authorize Kinder4Rescue Surgical Center to charge the following credit/debit card for the sole purpose of services (i.e. past services, visits, procedures/surgeries, and/or recurring charges) rendered on my pet, _____.

(patient's name, owner's name)

I authorize Kinder4Rescue Surgical Center to charge my credit/debit card for essential veterinary medical care not exceeding $ _____.

(enter max amount or write "open")

Credit/Debit Card Information

Credit/Debit Card Type (Please Circle): VISA MC DISC AMEX

Cardholders Name: _____

Credit/Debit Card Number: _____

Verification Number: _____ Exp. Date: _____

Billing Address on Card: _____ Zip: _____

E-mail Address: _____

I understand that this form is valid up to six weeks unless I cancel the authorization with written notification to Kinder4Rescue Surgical Center.

_____ _____

(cardholder's signature) (date)

Fingerprint: