



LEXINGTON VETERINARY GROUP

Internal Medicine and Surgery of Companion Animals

Main Hospital @ 39th: T: 212.889.7778 F: 212.661.0596

Chelsea @ 25th: T: 212.206.0655 F: 212.203.0655

CREDIT CARD AUTHORIZATION FORM

Thank you for selecting Lexington Veterinary Group as your pet's personal Veterinary Care Team. We are confident that your relationship will be 100% satisfactory. We ask our clients to pay for their pet's care at the time of treatment. For your convenience we welcome all major credit cards. In cases where your treatment is completed and your balance remains unpaid, your credit card can be charged automatically and kept on file.

Please be assured that Lexington Veterinary Group will keep all client information 100% confidential.

Kindly provide your endorsement and credit card number with expiration below.

Please read and sign one of the following below:

- *I decline to keep my card on file at this time but acknowledge that if decided to do so in the future and give my credit card number over the phone I accept the terms of this agreement.*

Signature: _____ Date: _____

- I authorize all veterinary services, including but not limited to, medical treatment, boarding, grooming, food, any delivery charges and prescription medications that have a balance left unpaid to be paid in full with the following credit card. I understand that any balance left on my account that was not paid at the time services were rendered will be charged to my credit card even in the unlikely event that I am not able to be reached by telephone. The credit card listed will be used for all of my pets that are seen at Lexington Veterinary Group at any of their two locations, even if a credit card authorization form is not signed for each pet. In the event that I may write a check and the check is returned for non-sufficient funds, I authorize the use of this card. Should my credit card get denied, these charges are due and payable directly upon notice. Lexington Veterinary Group reserves the right to discontinue use of my credit card as a method of payment without prior notice.

Date Signed: _____ / _____ / _____

Name Printed: _____

Signature: _____

(By signing above I understand and agree to the terms of this agreement)

Credit Card: (Please Circle) **MasterCard** **Visa** **Discover** **American Express** **Care Credit**

Credit Card #: _____

Date of Expiration: _____ / _____ Last 3 security digits located on back of card _____
MM / YYYY

Is the billing address the same as your home address? Yes No (if no please provide the billing address below)
