



Patient Name: \_\_\_\_\_ Date of Birth/Age: \_\_\_\_\_

Registered Name (if different): \_\_\_\_\_

Color(s): \_\_\_\_\_ Breed: \_\_\_\_\_ Gender: \_\_\_\_\_

Barn/Stable Name: \_\_\_\_\_ Stall #: \_\_\_\_\_

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## Payment Policy

***Payment is due at the time services are performed. For your convenience we accept cash, check and credit. If you would like to have your credit card information kept on file please read the following carefully and provide the required information.***

### ***Please elect your preferred payment method:***

I would like to pay cash for my appointments. I understand that payment is due at time of service.

I would like to pay by check. I understand there will be a \$35 return check fee if I have a returned check and will need to provide an alternate method of payment.

I would like to have my credit card charged at the time services are provided.

I would also like to have my credit card number kept on file.

### **Credit Card Authorization Agreement**

I, \_\_\_\_\_, give permission to Gold Star Equine  
(please print)  
Medicine, Inc., to keep my credit card information on file. I understand that this form will  
be secured in a locked cabinet and will be the only copy (ie. your credit card number will  
not be stored in a computer system or elsewhere).

Visa       Mastercard       Discover       American Express

Cardholder Name \_\_\_\_\_

Card Number \_\_\_\_\_

Expiration Date \_\_\_\_\_ Security Code \_\_\_\_\_

Billing Address (if different than on file) \_\_\_\_\_  
\_\_\_\_\_

Authorized Signature \_\_\_\_\_

Date Signed \_\_\_\_\_