FOR OFFICE USE ONLY:
Patient:_____
Medication:_____
_____
Start Date:_____


400 Stackstown Road
Marietta, PA 17547
717-361-8700

## Credit Card Payment Authorization Form

## KVA Auto Ship Medication Request

Please sign and complete this form to authorize Kopec Veterinary Associates to make a debit to your credit card for medications that you would like placed on auto ship.

The form only needs to be filled out one time. No additional payment information is required for future "auto ship" medications. By signing this form you give us permission to debit your account for the cost of the requested medications.

If you would like to cancel auto ship you may do so at any time by calling the KVA office (717-361-8700) or by e-mail (kvaequine@gmail.com).

This form is to be used for auto ship medications only. This form is NOT to be used for veterinary services rendered.

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**Please complete the information below:**

*** Form may be faxed (717-361-8708) or e-mailed (kvaequine@gmail.com) to the KVA office.**

Account Type: ☐ Visa ☐ MasterCard ☐ Discover ☐ Care Credit ☐ AMEX

Cardholder Name _____

Account Number _____

Expiration Date _____/_____ CVV # _____

****CARECREDIT ONLY*****

CareCredit Card Exp date ____/____ CVV# _____ OR Photo ID Exp Date ____/____ State _____

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Billing Address _____ Phone#_____

City, State, Zip _____ Email _____

SIGNATURE _____ DATE _____

*I authorize Kopec Veterinary Associates to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods on "auto-ship." KVA will keep the credit card on file. I certify that I am an authorized user of this credit card and that I understand the terms and conditions as outlined with my credit card company.*