



Mount Vernon Animal Hospital  
316 Vernedale Dr.  
Mount Vernon, Ohio 43050  
740-397-6958

New Client - Credit/ Debit Card Authorization Exam  
Client Service Agreement

Owner's Name: \_\_\_\_\_  
Home/Billing Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_  
Email: \_\_\_\_\_  
DOB: \_\_\_\_\_ Drivers License #: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_

Billing Information:

Name of Credit Card Holder as listed on Card: \_\_\_\_\_  
Check one: \_\_\_ Visa \_\_\_ MC \_\_\_ AmEx \_\_\_ Discover \_\_\_ Care Credit \_\_\_  
Credit Card Number: \_\_\_\_\_ Security Code: \_\_\_\_\_  
Expiration Date: \_\_\_\_\_  
Credit Card Billing Address (if different)  
\_\_\_\_\_  
\_\_\_\_\_

**Signature giving authorization to charge card once exam is complete and emailed:**  
\_\_\_\_\_ **Date:** \_\_\_\_\_