AllPets
ANIMAL CLINIC
1420 Lake Street
Spirit Lake, IA 51360
(712) 336-3647
www.allpetsac.com

# Emergency or After Hours Payment Form

## Owner's Information

Name:_____

Address:_____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

## Payment Information

☐ I would like to leave a signed check as form of payment.

Driver's License Number:_____ State of Issue:_____

☐ I would like to leave a credit or debit card number for payment:

☐ Visa ☐ Mastercard ☐ Discover ☐ Care Credit

Card Number_____

Expiration_____ Security Code_____ Billing Zip Code_____

Name as it appears on card_____

By signing this form I acknowledge that I am in agreement with AllPets Animal Clinic that the balance on my account will be paid in the manner in which I chose in the above payment information. I understand by paying in a check that if my check were to be returned, it will be my responsibility to cover not only the original invoice charges, but also a returned check fee. If I fail to pay those fees in full, AllPets Animal Clinic will turn my account over to their legal counsel for consideration. I also understand that if my card payment is declined, it is my responsibility to provide an alternate form of payment. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

_____ _____ Date___ /___ /_____

Signed Print Name