396 Orchard Road
Whitesboro TX 76273
(940)465-3354

**Please print and complete form entirely**

Horses Name: _____ Nickname: _____

Horses age: _____ Sex: Mare Gelding Stallion Color: _____Breed: _____

Owner Name: _____

Address: _____

City: _____State: _____Zip: _____

Telephone: _____

E-mail address: _____

Would you prefer email for billing purposes? Yes ☐ No ☐

Would you prefer ☐ weekly (credit card must be on file to run every Tuesday) or ☐ monthly (last Tuesday of month) billing?

Will this be an insurance case? Yes ☐ No ☐

## AUTHORIZATION TO DEBIT CREDIT CARD

I, hereby authorize Equine Sports Medicine Rehab to debit my credit or debit card for the purpose of paying my bill.

CARD HOLDERS NAME ON CARD _____

CARD NUMBER _____

EXPIRATION DATE _____

SECURITY CODE_____

BILLING ADDRESS (if different than above) _____

I understand that I may terminate this authorization at any time by providing Equine Sports Medicine Rehab notice of termination by phone or in writing. This however does not relieve me of the responsibility of paying my bill by other means.

I also understand that the information on this form is to be considered confidential and will be kept as such by Equine Sports Medicine Rehab.

By signing this, I state that I have read and agree with the above statements.

Signature_____Date_____