



Kulshan Veterinary Hospital

8880 Benson Road * Lynden, WA 98264

Phone: 360-354-5095 * Fax 360-354-3740

www.KulshanVet.com * DrKulshan@msn.com



Client Authorization

Cardholders Name: _____ Client ID#: _____

Billing Address: _____

City: _____ State/Prov.: _____ Zip/Postal Code: _____

Home Telephone: _____ Work: _____ Cell Phone/Pager: _____

Card Type (circle one): Visa Master Card Discover

Card Account Number: _____ Exp. Date: _____

Please charge my card –

- ☐ **One time only** – The card listed above will be billed for one time only - include comments and/or instructions below.
- ☐ By **Invoice** – the card listed above will be charged upon an invoice being entered into the computer. No statement will be sent.
- ☐ **Monthly** – at month end the credit card listed above will be charged for the full amount of the balance on the account. No statement will be sent.
- ☐ **Monthly +** - A statement will be sent to you at the beginning of the month following charges incurred on the account. If the account is not paid by the end of that month – the credit card listed above will be charged.
- ☐ For **Special Orders** – The credit card listed above will be charged for any special orders (food / medicine / supplies, etc).

Additional comments and/or instructions: _____

I, _____, authorize Kulshan Veterinary Hospital to use the above credit card toward any and all charges I may incur, unless other instructions are entered above. I must give written notice to cancel this authorization. I understand that I am responsible for all costs of treatment. Should any of the above information change, I agree to notify Kulshan Veterinary Hospital immediately. Should it become necessary for Kulshan Veterinary Hospital to obtain legal collection for non-payment, I agree to pay all fees and court costs. My account balance will accumulate 1.5 percent (\$1.00 min.) interest monthly on my outstanding balance.

Signature: _____ Date: _____