Credit Card Payment – Margie Gayford Clinic

1. Information (Please print clearly)

Riders Name: _____

Mailing Address: _____

City: _____ Postal Code: _____ Telephone Number: _____

2. Description of Services

☐ Rider ($169.50 per) Audit: ☐ Saturday ☐ Sunday (1 Day $22.60 per - 2 Day $33.90 per)

Notes: _____

3. Payment Options

☐ Visa ☐ Mastercard ☐ Discovery

4. Credit Card Information

Credit card # __ __ __ __ - __ __ __ __ - __ __ __ __ - __ __ __ __

Expiry: __ __ / __ __ CSV code: __ __ __

Name as it appears on card: _____

5. Amount Authorized: $_____

POLICIES AND CONDITIONS

In this authorization, "you" and "your" refer to each holder of the Pre-Authorized account who signs this form. You authorize us to debit your account for all amounts owed to us under the Pickering Horse Centre Ltd. for the payment amount indicated under the Amount Authorized on this form. You have read, understand and agree to the terms of the Pre-Authorized Payment Agreement.

_____
Signature of account holder

_____
Name (Please Print)

_____
Date (Month/Day/Year)