P.E.T.S. Clinic Monthly Recurring Giving Form

You authorize regularly scheduled charges to your Credit Card or Bank Account. You will be charged the amount indicated below each billing period. A receipt for each payment will be provided to you and the charge will appear on your Credit Card or Bank Account Statement. You agree that no prior-notification will be provided unless the date or amount changes, in which case you will receive notice from us at least 10 days prior to the payment being collected. If using your bank account, please include a voided check which constitutes a receipt of donation for your bank.

I _____ authorize P.E.T.S. Low Cost Spay and Neuter Clinic to charge my Credit Card or Bank Account below for $_____ beginning on _____ (Date) every "month".

Notes (for your records): _____

Billing Details

Billing Address _____ Phone # _____

City, State, Zip _____ Email _____

Credit Card Information

❑ - Visa ❑ - MasterCard ❑ - AMEX ❑ - Discover

Cardholder's Name - _____

Credit Card Number - ____-____-____-____

Expiration Date - ____/____

Security Code (CVV) - ___

Bank (ACH) Information (Please Include a Voided Check Which Constitutes a Donation.)

❑ - Checking Account ❑ - Savings Account

Name on Account - _____

Bank Name - _____

Account Number - _____

Routing Number - _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the merchant in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. In regard to recurring banking transactions, a return for Non-Sufficient Funds (NSF) will cancel current and future payments. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank; so long as the transactions correspond to the terms indicated in this authorization form.

Individual's Signature _____ Date _____

Please fill the required sections and mail (with a voided check if authorizing Bank Payments) to:

P.E.T.S. Clinic

PO BOX 4669

Wichita Falls, TX 76308