

53 Mount Nebo Road • Newtown, Connecticut 06470 (203) 426-5040

## **CLIENT REGISTRATION / VETERINARY SERVICE AUTHORIZATION**

Welcome to our practice. Thank you for retaining Connecticut Equine Practice (CEP) as your provider for your horse's veterinary care. This agreement will govern the veterinary services we provide to the horse owner ("Client") either directly or as approved by an authorized agent listed in this Agreement.

This Agreement applies to all horses owned or leased by Client and applies to any and all veterinary services provided by CEP, including but not limited to services, procedures, surgery, medicines, and farm calls to any and all horses on Client's behalf, whether or not the horse(s) is/are listed in this Agreement.

## **Client Information**

Name:

Address:					
City/State/Zip:					
Home Phone:		Cell Phone:	Work Phone:		
E-Mail Address:					
Horse Information					
Horse Name	Breed	Color	Age	Gender	
					_
Boarding Stable:			Phone:		
Authorized Agent For	Providing Veterin	Phone:			
Emergency Contact O	ther Than Owner:	Phone:			
Insurance Company/P	olicy No./Phone N	No:			

By signing this document, you are forming a contract with Connecticut Equine Practice, LLC. This contract creates certain rights and obligations including, but not limited to, those described below. Payment is required at the time of service. Insurance claim payments for a major medical claim will be sent to you directly from your insurance company. Thank you.

I understand and agree that:

I am financially responsible for paying fees for veterinary services provided by Connecticut Equine Practice, LLC and for any finance and collection fees associated with my account.

## Choose one:

- □ I will pay each invoice by automatic charge to a credit or debit card that I provide to Connecticut Equine Practice, LLC. I will ensure that sufficient funds are available on the card to pay my invoice in full.
- □ I will pay all Connecticut Equine Practice, LLC invoices within 30 days of service date by cash, check, or credit or debit card. Visa, MasterCard, American Express, and Discover are accepted.
  - Any balance on my account that is unpaid 30 days after the original service date will be past due and subject to finance charges of 1.5% per month (18% per annum) plus a re-billing charge.
  - I grant authority to Connecticut Equine Practice, LLC to pay any past due balance on my account via the credit/debit card I provided to them. I will have sufficient funds available on the card to pay the past due balance in full.

The authority to charge my credit or debit card remains in effect until I cancel that authority via written notice to Connecticut Equine Practice, LLC at least 30 days before my intended cancellation.

I am the legal owner or designated agent for the legal owner of the patient(s) listed on this registration form. I have the authority to execute this document.

	Signature	Printed I	Printed Name				
	CARD INFORMATION						
	Circle Card Type: Visa	MasterCard	Discover	American Express			
	Card Number		_ Exp Date _	CV			
Card Billing Address (include house #/zip)							
Cardholder Name (please print)							
	Cardholder Signature						