NORTHEAST EQUINE **VETERINARY DENTAL SERVICES, LLC**

NEW CLIENT INFORMATION
VETERINARY SERVICE CONTRACT

Thank you for choosing Northeast Equine Veterinary Dental Services. By signing this document, you are forming a contract with Northeast Equine Veterinary Dental Services, LLC to provide veterinary medical services to horses owned by the undersigned, and agree to bear financial responsibility for any provided veterinary care.

HORSE OWNER INFORMATION (please print)

NAME:_____
ADDRESS:_____
CITY:_____STATE:_____ZIP:_____
PHONE:_____CELL:_____WORK:_____
EMAIL:_____
CONTACT (if different from owner):_____PHONE:_____

HORSE INFORMATION

HORSE #1:
Show Name:_____Barn name:_____
Age:_____Breed:_____Gender:_____Color:_____
HORSE #2:
Show Name:_____Barn name:_____
Age:_____Breed:_____Gender:_____Color:_____
HORSE #3:
Show Name:_____Barn name:_____
Age:_____Breed:_____Gender:_____Color:_____
HORSE #4:
Show Name:_____Barn name:_____
Age:_____Breed:_____Gender:_____Color:_____

HORSES LOCATION:
Stable:_____Address:_____
City:_____State:_____Zip:_____Phone:_____
Trainer/Authorized agent:_____Phone:_____
Previous or current veterinarian:_____
Whom may we thank for referring you to us? _____

AUTHORIZATION TO TREAT (required – please initial after each statement)

1. I hereby authorize Northeast Equine Veterinary Dental Services to provide veterinary care to my horse(s) at my request as well as in my absence at the request of my trainer or barn management._____
2. I agree that I bear financial responsibility for any and all costs associated with veterinary care or services provided to my horse(s) by Northeast Equine Veterinary Dental Services._____
3. This contract shall apply to any and all horses owned, leased, or under the care of the undersigned, whether or not the horse(s) are listed on this form._____

PRINT LEGAL OWNER'S NAME:_____
OWNER'S SIGNATURE:_____
DATE:_____

NORTHEAST EQUINE **VETERINARY DENTAL SERVICES, LLC**

PAYMENT POLICY

Thank you for choosing Northeast Equine Veterinary Dental Services. Our payment policy is designed to keep our billing process straightforward and keep our fees as low as possible. We appreciate your business.

We request that payment for veterinary services provided to your horses be made at the time of service. We also request that a current credit card be placed on file with our office. Your credit card will not be charged if payment is made at the time of service. If payment is not made at the visit your credit card will be charged within 3 days of your appointment. Insurance claim payments for a major medical claim will be sent to you directly from your insurance company.

CREDIT CARD INFORMATION

VISA MASTERCARD (please circle one)

CREDIT CARD NUMBER: _____
Exp date: _____ Security code (last 3 numbers on back of card) _____
NAME ON CREDIT CARD: _____
BILLING ADDRESS (if different from above): _____

ACKNOWLEDGEMENT OF PAYMENT POLICY – please initial after statement

If payment is not made at the time of service we understand that signals my consent to have my account settled by charging the balance to my credit card, unless prior arrangements have been made. _____

PRINT LEGAL OWNER'S NAME: _____
OWNER'S SIGNATURE: _____
DATE: _____