



Fairfield Equine

## VETERINARY SERVICES CONTRACT – REFERRAL CLIENTS

Please Note: By signing this document, you are forming a contract with FAIRFIELD EQUINE ASSOCIATES, P.C. This contract creates certain rights and obligations including, but not limited to, those described on the second page of this contract. 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.

### HORSE OWNER INFORMATION (please print)

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: \_\_\_\_\_ MOBILE: \_\_\_\_\_

E-MAIL: \_\_\_\_\_ PREFERRED CONTACT \_\_\_\_\_

EMPLOYER NAME: \_\_\_\_\_ TEL : \_\_\_\_\_

AUTHORIZED AGENT: \_\_\_\_\_ TEL: \_\_\_\_\_

### HORSE INFORMATION

HORSE'S NAME: Show name: \_\_\_\_\_

Barn name: \_\_\_\_\_

Age: \_\_\_\_\_ Breed: \_\_\_\_\_ Color: \_\_\_\_\_ Gender: \_\_\_\_\_

Trainer: \_\_\_\_\_ Tel#: \_\_\_\_\_

Is your horse on the Preventicare Program? Yes: \_\_\_\_\_ No: \_\_\_\_\_

In Case of Emergency, Notify: \_\_\_\_\_ Tel#: \_\_\_\_\_

Relevant Medical History: \_\_\_\_\_

Referral Veterinarian: \_\_\_\_\_

Insurance Company (if any): \_\_\_\_\_ Tel#: \_\_\_\_\_

**ACCOUNT INFORMATION – Review and initial each line (required)**

1. I understand that I must pay the full balance due upon end of hospital/clinic stay. Any unpaid balance will be automatically charged to your credit card if not paid within 30 days. \_\_\_\_\_
2. If your wish is for us to automatically charge your credit card at the end of the stay, please initial here, otherwise, payment will be in the form of a check or cash. \_\_\_\_\_
3. I hereby authorize Fairfield Equine Associates, PC to provide routine care to my horse(s) in my absence or at the request of my barn management. \_\_\_\_\_
4. This contract shall apply to any and all veterinary services provided by Fairfield Equine Associates, PC to any and all horses on your behalf, whether or not the horses (s) are listed on Page 1 of this form. \_\_\_\_\_
5. Late charges shall be applied to all accounts overdue at a rate of 1% monthly or 12% per annum. \_\_\_\_\_
6. Should Fairfield Equine Associates, PC be forced to commence administrative and/or legal action to collect unpaid invoices from you:
  - a. You consent to personal jurisdiction of the courts of the State of Connecticut over you,
  - b. You agree to pay all costs, expenses and reasonable attorney's fees incurred by Fairfield Equine Associates, PC that are associated with such an action. \_\_\_\_\_
7. You represent that you are presently able to comply with the payment terms herein. \_\_\_\_\_
8. I understand that I must cancel or reschedule an appointment 24 hours in advance of the appointment. If I am not able to comply with this policy, I may be billed for any charges associated with any and all services or supplies completed in preparation for the appointment. \_\_\_\_\_
9. **A deposit is required for hospitalized cases as follows: \$4,000 for Colic Surgeries \$2,000 for Medical Colic Treatments \$2,000-\$3,000 for Elective Surgeries** \_\_\_\_\_

**\*\*VETERINARY SERVICES WILL NOT BE PROVIDED WITHOUT YOUR SIGNATURE & INITIALS\*\***

**CREDIT CARD INFORMATION: American Express Visa Master Card Discover**

# \_\_\_\_\_ Exp. Date \_\_\_\_\_

Name on Card: \_\_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**GUARDIAN'S SIGNATURE (Owner Under 18 Years of Age):** \_\_\_\_\_

**Printed:** \_\_\_\_\_