COOSA VALLEY EQUINE CENTER, PC

1330 Mineral Springs Road
Pell City, AL 35125
Phone: 205-338-1111 Fax: 205-338-3242

VETERINARY SERVICES CONTRACT

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

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.

Owner Information (Please Print) Today's Date: _____

Owner's Name: _____ Social Security #: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

UPS Address: _____ City: _____ State: _____ Zip: _____

County: _____ Referred by: _____

Home #: _____ Cell #: _____ Email:_____
(FOR CLINIC USE ONLY....RADIOGRAPHS, REMINDERS)

Employer's Name: _____ Work #: _____

Spouse's Name: _____ Cell #: _____

Spouse's Employer: _____ Work #: _____

READ THE FOLLOWING AND INITIAL:

1. I hereby authorize Coosa Valley Equine Center, P.C., to provide services to my horse(s) in my absence or at the request of my trainer or barn management. This applies to any and all services. ____

2. I understand that I must pay the **full balance** due at the end of each visit. Payment can be made by cash, check, Visa, MasterCard, American Express or CareCredit. ____

3. Should there be an emergency or special circumstance and only partial payment made at the time of the visit, I understand the remaining balance must be paid in full within 30 days. ____

4. Should Coosa Valley Equine Center, P.C., be forced to commence administrative and/or legal action to collect unpaid invoices from you:
   You understand that a late charge will be applied to all accounts overdue at a rate of 1.5% monthly.
   You consent to personal jurisdiction of the courts of the State of Alabama over you,
   You agree to pay all costs, expenses, collection fees and reasonable attorney's fees incurred by Coosa Valley Equine Center, P.C., associated with such action. ____

5. I understand that a deposit **is required** for hospitalized cases as follows. ____

   $3,000 for Colic Surgeries $1,000 for Medical Colic Treatments ½ Estimated $ for Elective Surgeries

American Express Visa MasterCard CareCredit (circle one)

CREDIT CARD #:_____ EXP DATE: _____

NAME ON CARD: _____ V CODE: _____

Owner or Representative's Signature: _____