Crossroads Equine Veterinary Services, LLC

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We strive to give you the best care and service available. Please fill out this form so we can better serve you. Thank you for choosing Crossroads Equine Veterinary Services as your equine veterinary care provider.

Owner's Name_____Spouse/Other_____

Address_____

City_____State_____Zip Code_____

HomePhone_____Cell_____E-mail _____

Employer_____WorkPhone_____Driver's License#_____

Boarding Stable_____Referred By_____

THE PRIMARY CONCERN OF OUR CLINIC IS THE CARE AND TREATMENT OF OUR PATIENTS. HOWEVER, TO CONTINUE TO PROVIDE PROFESSIONAL CARE, WE MUST ESTABLISH THE FOLLOWING POLICY:

1)Payment is required in full at the time services are rendered.

2)Methods of payment are (cash, check, Visa, Mastercard, Discover, American Express.) This will be established before services are rendered.

3)A $36.50 service charge will be charged for all returned checks.

4)An emergency fee of $100.00 will be added to regular charges for all after hours and emergency cases.

5)Accounts requiring legal action agree to pay collection costs and reasonable attorney's fees.

6)Accounts over 30 days will accrue a service charge of 2.0% monthly.

7)If regular monthly payments are not established and continued before 120 days, accounts will go to collections and accrue up to an additional 33% of the account balance for collections fees.

I hereby authorize the veterinarian to examine, prescribe for, or treat my animals. I have read and fully understand the above policy and agree to the terms stated above.

Signature:_____Date:_____