



### VETERINARY SERVICE AGREEMENT

#### Horse owner information

**\*Account must be set up by an authorized individual over 18 years of age\***

NAME: \_\_\_\_\_ PHONE(s): \_\_\_\_\_

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

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

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

ADDITIONAL NAME(S) / OWNER ON ACCOUNT  
: \_\_\_\_\_

#### Horse Information(Can attach additional pages if more than 10 horses)

<u>Name</u> (barn and registered name)	<u>Breed</u>	<u>Color</u>	<u>Age</u>	<u>Sex</u> (G/S/F) G=Gelding S=Stallion F=Mare	<u>Identification(microchip, lip tattoo, brand)</u> Indicate where identifier is	<u>Check this box if horse is insured</u> (see information under chart)

ROCKY MOUNTAIN  
EQUINE CLINIC


LOCATION OF HORSE(S) IF DIFFERENT FROM OWNER ADDRESS:

---



---

**AUTHORIZED AGENT(S):**

NAME:

PHONE:

NAME:

PHONE:

NAME:

PHONE:

\_\_\_\_(Initials required if agents listed) I authorize the release of medical information to my agent(s) and allow them to make treatment decisions for my horse(s) including, but not limited to, appointment scheduling, diagnostics, treatment protocols, and medications. I am responsible for payment of these routine or emergency appointments at time of service.

\_\_\_\_(Initials required if agents not listed) I understand that if I have not listed an authorized agent, that I am the only person who can request veterinary attention for my horse(s), and that in the event of an emergency, if I cannot be reached, Rocky Mountain Equine Clinic will not provide emergency treatment for my horse(s). I am responsible for payment of emergency services at time of service.

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

Policy #: \_\_\_\_\_ Insurance Phone Number: \_\_\_\_\_

**\*\*Payment is required at the time of service. Any payment from a medical claim will be sent to you directly, as we do not bill the insurance company\*\***

**SOCIAL MEDIA PREFERENCES**

\_\_\_\_(Initial or leave blank if not desired) I allow Rocky Mountain Equine Clinic to use photos and/or diagnostic imaging (radiographs, ultrasound, etc.) of my horse(s) for educational purposes on the practice's website and social media page. I understand that Rocky Mountain Equine Clinic will treat such information in a respectful manner and



ROCKY MOUNTAIN  
EQUINE CLINIC

will not share any confidential information such as horse name or any of my personal information.

### **INVOICING PREFERENCES**

\_\_\_\_(Initials required) I understand that the email provided is RMEC's main communication method for payment receipts, any invoices (which for any reason) are unpaid, medical records, and reminders.

\_\_\_\_(initials if preferred) I would like to additionally receive payment receipts and medical records in the postal mail.

### **VETERINARY SERVICE AGREEMENT TERMS AND CONDITIONS**

Thank you for choosing Rocky Mountain Equine Clinic ("RMEC") as your provider of equine veterinary health services. This Agreement will govern the veterinary services we provide to the Horse Owner ("Client") either directly or as approved by the 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 RMEC, including but not limited to services, procedures, medicines, and farm calls to any and all horses on the Client's behalf, whether or not the horse(s) are listed on page one of this Agreement.

#### **SERVICES:**

By signing the Veterinary Service Agreement, I authorize Rocky Mountain Equine Clinic to provide routine and emergency care to my horse(s) in my absence or at the request of my agent(s) listed above. I authorize use of appropriate sedation and/or other medication(s). I understand that RMEC personnel will be utilized as deemed necessary by the attending veterinarian. I understand no guarantee has been made as to results or cure. I understand that there may be risks involved with some of these procedures.

#### **EMERGENCY SERVICES:**

I understand that RMEC will make every reasonable effort to provide emergency services if I am a client in good standing. If I am going to be out of town, I will fill out treatment authorization form with my preferences indicated.



### **PAYMENT POLICIES**

1. I represent that I am presently able to comply with the payment terms herein, and that if I should become unable to make timely payment of outstanding invoices, I will notify RMEC immediately.
2. I understand that I must pay all accounts in full at time of services; whether routine or emergency.
3. If for any reason an invoice is not given to me at time of service, I will pay my entire bill in full within 30 days of receipt.
4. Late charges shall be applied to my account at a rate of 1.5% per month with a \$5 minimum per billing cycle for any overdue balance.
5. Should RMEC be forced to commend administrative and/or legal action to collect unpaid invoices from me:
  - a) I consent to personal jurisdiction of the court of the State of Colorado.
  - b) I agree to pay all costs, expenses and reasonable attorney's fee incurred by RMEC that are associated with such action.
6. I agree to provide RMEC with current information and data regarding any changes in address, credit cards or expiration dates, and RMEC is authorized to revise its records accordingly.

---

Signature of owner

---

Date signed