Westview Veterinary Hospital, Inc.
3032 Napoleon Road, Fremont, Ohio 43420
419-332-5871

EQUINE NEW CLIENT FORM

Welcome and thank you for choosing us to care for your animal(s). Please take a few minutes to fill out this client information for yourself and your animal(s). If you have any questions, please don't hesitate to ask.

Owner Name:_____
Address:_____
City:_____ State:_____ Zip:_____County:_____
Phone #: _____ Cell Phone:_____
E-mail_____
DL#_____ SS#_____
Employer:_____ Employer Phone:_____

Significant Other:_____
Cell Phone:_____ Alt#:_____
DL#:_____ SS#:_____
Employer:_____ Employer Phone:_____
(SS number required for both Owner and spouse on any account not paid in full)

Address where horses are located if not same as above:
Farm Name: _____
Address: _____

Tax Exempt Status_____

I hereby authorize the veterinarian to examine, prescribe for, or treat my animal(s). I assume responsibility for all charges incurred in the care of my animals. I also understand that these charges will be paid at the time of release and that a deposit is required for treatment.

_____ _____
Signature of responsible Owner/agent Date

Farm Call Payment Agreement

Owner Name: _____

PAYMENT OPTIONS (please initial):

_____ **I wish to pay the balance in full at time of service with cash, check, or credit card. Payment for all in clinic or haul-in appointments are due at time of service.**
Keep credit card on file for future use: YES_____ NO_____

OR:
_____ **I wish to receive an invoice and mail in payment, and I understand that my credit card is required to be kept on file.** By initialing, I understand that if payment has not been remitted within 60 days of service, the full amount will be charged onto the credit card. In the unlikely event that the credit card will become declined, action will be taken for collection of the balance due on the account.

CREDIT CARD INFORMATION
Circle - VISA MASTERCARD DISCOVER AM EX
Card Number: _____
Expiration Date: _____ CCV Code: _____ Zip Code: _____

BILLING INFORMATION (if different than above)
Name on Card: _____ Phone: _____
Billing Address for card: _____ City: _____ State: _____ Zip: _____

Communication preferences:
_____I prefer a mailed copy of my invoices and/or receipts
_____I prefer an e-mailed copy of invoices and/or receipts.

I understand that if my bill is not paid in full after 30 days from time of service, it is subject to a service charge at 2% monthly. Billing occurs on the 1st of every month. I further understand that as the Owner, I am responsible for all court costs and lawyer fees if account is turned over to collection.

_____ _____ _____
Signature of responsible Owner/agent Phone No. Date

_____ _____ _____
Spouse/Significant other Phone No. Date
Both parties on account must sign or give verbal acknowledgement to staff over phone

_____ _____
Staff Signature Date