New Client Veterinary Services Agreement

Thank you for retaining Skillman Veterinary Services as your provider of veterinary health services. This agreement applies to all horses owned or leased by Client and applies to any veterinary services provided by Skillman Vet Services, including but not limited to, in or out–patient services, procedures, medications filled, supplies, and farm calls to any and all horses on Client's behalf. Payment is due at time of provided service using cash, check, or CC. We do not accept post-dated checks.

Horse Owner Information

Name:_____
Name of Parent or Guardian (if Applicable): _____
Address: _____
City: _____ State: ___ Zip: _____
Phone: _____ Cell: _____ Work: _____
E-Mail (Invoices, Receipt, and Communication sent here):_____
Address where horse is Stabled: _____
_____

Horse(s) Information

Horse #1 Barn Name: _____
Registered Name/How you want written on health docs):
_____

Breed: _____ Age: _____ Sex: Mare Gelding Stallion
Special Markings (Tattoos, Brands, etc.) _____
Reason your horse is being seen today if applicable:_____
_____

Horse #2 Barn Name: _____

Skillman Veterinary Services
PO Box 232
McCordsville, IN 46055
3178296530

SkillmanVeterinaryServices@Gmail.com
www.SkillmanVet.com

Registered Name/How you want written on health docs):
_____

Breed: _____ Age: _____ Sex: Mare Gelding Stallion
Special Markings (Tattoos, Brands, etc.) _____
Reason your horse is being seen today if applicable:_____
_____

Horse #3 Barn Name: _____
Registered Name/How you want written on health docs):
_____

Breed: _____ Age: _____ Sex: Mare Gelding Stallion
Special Markings (Tattoos, Brands, etc.) _____
Reason your horse is being seen today if applicable:_____
_____

Horse #4 Barn Name: _____
Registered Name/How you want written on health docs):
_____

Breed: _____ Age: _____ Sex: Mare Gelding Stallion
Special Markings (Tattoos, Brands, etc.) _____
Reason your horse is being seen today if applicable:_____
_____

Authorized Agent(s):
Name: _____ Phone #:_____

I authorize my agent to make appointments and order medications for my horse (s) and give him/her permission to charge such appointments/ medications to my credit card.__Yes __No
I authorize the release of medical information about my horse(s) to my agent __ Yes __No
If I am not able to be reached in an emergency I authorize my agent to make decisions on my horse's treatment up to this $ amount. ____

Account Information (Required–Please Initial after each Statement)

1. I understand that I must pay at time of service or have my credit card on file billed on the same day. _____

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2. I would like to keep a credit card on file for faster processing for medication refill and in the event I am unable to be reached in an emergency ___ Yes ___ No
   **We will not collect Credit Card Info via paper documents and will call you over a secure line to collect this information where it goes directly into our encrypted, secure software program.
3. I hereby authorize Skillman Veterinary Services to provide routine and emergency care to my horse(s) in my absence or the request of my authorized agent. ____
4. I understand that any appointments made that are a no-show by owner or authorized agent with less than 24 hours cancellation will incur a $75 fee____
5. I agree to provide Skillman Veterinary Services with current information regarding any changes in address, credit cards, expiration dates, and Skillman Vet Services is authorized to revise its records accordingly.
6. All unpaid accounts at **30 days** will be considered past due and receive a 5% late fee for each remaining month they retain a balance. Client shall pay all costs and expenses, including attorney's fees and collection fees which are incurred by Skillman Vet Services to collect any past due accounts. _____

By signing below, I have read, understand, and voluntarily comply with the terms and conditions of the Agreement as a legal enforceable contract with Skillman Veterinary Services. I further understand and agree that veterinary services cannot be provided without my initials where requested above. If I am opting out of providing my credit card then I realize that I must provide payment at each appointment and the provisions enumerated above will be in effect for instances of late or non-payment as indicated.

Printed Legal Client Name: _____

Client's Signature:_____Date:_____

Guardian's Name (if client under 18 years of age):
_____

Guardian's Signature:_____

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