Palm Beach Equine Clinic

Client Authorization Form

Client (Owner) Name: ____

Mailing Address: ________________________ _ _______________________________________

Home: ______________________ Work: ____________________ Cell: ____________________ Fax: ______________

Email: ____

Permanent Address: ____

Driver's License Name: __________________________ #: ____________________________ State: _____ Exp: ______

Referred by: ____ Horse Registered Name: ______________________

Horses Alternative: ______________________ Microchip#: ____________________ Brand/Tattoo: __________________

Horses Discipline: _________________ Breed: __________________ Age: ___ Gender: *Mare Stallion Gelding* Color: _________

Trainer: ______________________________ Groom: ___________________________ Phone: ____________________

Barn Name, Address and Phone Number Where Your Horse Is Stabled:

____

Gate Codes: ____________________ Barn Manager authorized to call on your behalf: Yes: ______ No: _______

The following people listed below are authorized to call on my behalf for veterinary services, medications or records needed:

____ **Phone:** _________________________

____ **Phone:** _________________________

PBEC PAYMENT POLICY, ALL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED

We require all clients to have a credit card on file with us. We accept cash, check, Care Credit or credit card. For the clients electing to pay by credit card, the invoices will be sent first via email then we will be debiting the balance with your credit card on file.

THE BALANCE ON ANY PAST DUE ACCOUNT WILL AUTOMATICALLY BE CHARGED ON THE CREDIT CARD WE HAVE ON FILE IF WE DO NOT HEAR BACK FROM YOU WITHIN 60 DAYS. BALANCES OVER 30 DAYS WILL INCUR 1.5% INTEREST CHARGE. ANY NSF PAYMENT WILL INCUR A FEE OF $25.

Name of Cardholder to be placed on file: ____

VS/MC/DSC/AMEX____ **Exp. Date**____________ **CVV:** _________

Credit Card Billing Address: ____

City: _________________ **State:** _____ **Zip:** _______ **Cardholder's Signature:** ______________________________

I fully understand that professional fees, medications dispensed or mailed are to be paid at the time of services rendered. A deposit is required on all horses admitted into the hospital and the balance must be paid before or upon discharge.

SIGNATURE: ____ **DATE:** ___________________________________

Please call Debra Gensbugel, Accounts Manager with any questions or concerns. All payments are to be mailed to our office: 13125 Southfield Road, Wellington, Florida 33414 Direct Accounting Cell (561)914-0815 debra.gensbugel@equineclinic.com