PLEASE COMPLETE THESE FORMS AND RETURN VIA FAX or MAIL. THANKS!

CLIENT REGISTRATION INFORMATION:

Name	
Spouse	
address	
city	
State	
Zip Code	
Home phone	
Work phone(s)	
cellular/mobile	
emer. contact	

Whom may we thank for referring you to us?_____

Email address:_____

OWNER'S AUTHORIZATION FOR STABLE OR AGENT TO OBTAIN VETERINARY CARE

I hereby authorize _____
to contact Alpine Equine Hospital to obtain veterinary care (routine or emergency) for

Patient's Name_____Color_____

Breed _____Age_____Sex_____

MEDICAL HISTORY: Please attach or make arrangements to send/fax copies of the patient's previous medical history. Please include information on Allergies, past medical history/problems current therapy and/or medication, farrier name, phone # and any corrective shoeing, and INSURANCE INFORMATION. Thank you for helping us care for your animal better by providing this information.

OWNER AUTHORIZATION TO PROVIDE VETERINARY CARE

I am the owner / agent and have the authority to execute this authorization. I hereby authorize the veterinary practice of Alpine Animal Hospital PC, to provide veterinary care for my animals.

Veterinary care includes the performance of procedures and the use of appropriate anesthetics and other medications as deemed necessary in the exercise of the practice veterinarian's professional judgment.

I further understand that I am financially responsible for payment of all fees for veterinary services, late charges and/or collection costs as described in this practice's Financial Policy.

Date

Print Name of Owner or Agent for Owner:

Signature of Owner or Agent for Owner:

Credit Card Authorization Form

Our client service representatives create all invoices from travel sheets filled out during your animal's exam and/or hospitalization. You will need to leave a payment check at the appointment or call our office in advance to give us your credit card information for payment if charging has not been pre-approved on your account. We'll mail an invoice with a copy of your check or credit card receipt.

To be billed for veterinary services, rather than pay invoices at each appointment, please complete the information below and sign. We will bill your credit card the 25th of each month and mail all receipts.

Cardholder's name as it appears on credit card:

Visa/MC//CareCredit # _____ Exp date: _____

(please circle credit card type)

3 Digit V Code (on back of card-last 3 numbers) _____

I understand and agree that any past due balance (over 30 days from date of service) on my account will automatically be billed to my credit card I also understand and agree that this authorization to pay any past due balance with my credit card remains in effect - until cancelled by me with 30 days written notice. We charge 18% per annum (1.5% per month) on all balances over 30 days old.

Signature: _____

Date: _____