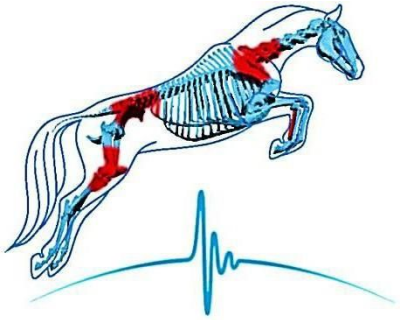

EQUINE SPORTS MEDICINE
OF MARYLAND
720 N. Hocksville Road, Hampstead, MD 21074 (866)930-9470
(410)239-2323 Fax (410)374-2901

COOPER WILLIAMS, VMD, DACVSMR

MAGDA STEWART, DVM

VETERINARY SERVICES CONTRACT

As a courtesy to our clients we do not require payment at the time of service. In order to accomodate this courtesy we ask that you provide the following information and agree to the terms and conditions on this document.

HORSE OWNER INFORMATION

Name _____

Address _____

_____

Phone # _____

Email _____

HORSE INFORMATION

Horse's Name(s) _____

_____

Stable_____

Stable Address _____

_____

Phone # _____

Authorized Agent _____

In Case of Emergency, Notify _____

Emergency Contact Phone # _____

Insurance Company (If Any) _____

Insurance Company Phone # _____

By signing this document you are forming a contract with EQUINE SPORTS MEDICINE OF MARYLAND. This contract creates certain rights and obligations including, but not limited to, those described on the second page of this contract. Payment is required upon receipt of invoice. Insurance claim payments for a major medical claim will be sent to you directly from your insurance company. If at any time you have questions about an invoice please contact us.

VETERINARY SERVICES CONTRACT CONT…

ACCOUNT INFORMATION (REQUIRED-PLEASE INITIAL AFTER EACH STATEMENT)

I understand that I must pay all accounts in full upon receipt of invoice. _____

If you arrange an automatic charge to your credit card monthly, we will agree to do so. Any time a charge is applied to your card we will send you a statement and invoice for your records.
Please circle YES or NO for automatic payment. _____

If we have not received payment in full within 30 days of invoice, you hereby consent and agree to have your account settled by immediately charging the balance to your credit card. _____

I hereby authorize EQUINE SPORTS MEDICINE OF MARYLAND to provide routine care to my horse(s) in my absence at the request of my barn management. _____

This contract shall apply to any and all veterinary services provided by EQUINE SPORTS MEDICINE OF MARYLAND to any and all horses on my behalf, whether or not the horse(s) are listed on this form. _____

Late charges shall be applied to all accounts overdue at the rate of 1% monthly or 12% annually. _____

Should EQUINE SPORTS MEDICINE OF MARYLAND be forced to commence administrative and/or legal action to collect unpaid invoices, I consent to service of process by means of nationally recognized (in the USA) overnight carrier with respect to any such claim by delivery of summons and complaint to the address on this contract. _____

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 immediately contact EQUINE SPORTS MEDICINE OF MARYLAND. _____

****VETERINARY SERVICES WILL NOT BE PROVIDED WITHOUT YOUR SIGNATURE AND INITIALS****

I HEREBY REQUEST AND AUTHORIZE EQUINE SPORTS MEDICINE OF MARYLAND TO CHARGE MY CREDIT CARD LISTED BELOW FOR SERVICES RENDERED IN ACCORDANCE WITH THE TERMS CITED ABOVE.

Credit Card # _____ Exp. Date _____

VISA MASTERCARD DISCOVER AMEX (Circle One) Security Code _____

Employer Name _____ Phone # _____

Print Legal Owner's Name _____

Owner's Signature _____

Guardian Signature (If owner under 18 years of age) _____