

WALKERSVILLE VETERINARY CLINIC
10559 GLADE ROAD
WALKERSVILLE, MD 21793
301-898-7676

NEW CLIENT INFORMATION AND AGREEMENT
LARGE ANIMAL
(THIS REPORT IS CONFIDENTIAL)

Date: _____ Account Type: _____ Individual _____ Joint _____

Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Driver's License Number: _____ DOB: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

e-mail: _____

Name of Farm: _____

Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Driver's License Number: _____ DOB: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

e-mail: _____

PLEASE READ CAREFULLY: Walkersville Veterinary Clinic Payment Policy

1. Payment is required at time of service on the first visit. Future visits may be billed as long as a current credit card is maintained on file. Alternate payment arrangements can be made with approval from Walkersville Veterinary Clinic pending a signed Payment Agreement being on file.
2. Client(s) agree(s) to pay the charges associated with the veterinary services rendered to Client(s) animal(s). Client(s) agree(s) to pay all charges incurred during any period(s) when payment for such charges is pending determination by a third party. Any disputed amount shall be reported to Walkersville Veterinary Clinic in writing within ten (10) days of the original statement date or the claim is forever waived.

3. All charges for goods and services are due and payable within 30 days of statement date; for any amounts unpaid after 30 days, a one and one-half percent (1.5%) monthly finance charge will be added to the account.
4. Walkersville Veterinary Clinic will discontinue providing veterinary services for any account that is 60 days past due, unless special arrangements have been made in advance. If a signed Payment Agreement is not on file, Walkersville Veterinary Clinic will charge the credit card account listed below for the full balance on Client(s) account, without further notice.
5. Client(s) shall be charged Twenty-Five Dollars (\$25.00) for the first check returned for insufficient funds. Client(s) shall be charged Thirty-Five (\$35.00) for any subsequently returned checks.
6. If collection proceedings are brought against Client(s) for any unpaid balance on account, Client(s) agree(s) to pay all costs, including any attorney fees and other reasonable costs of litigation.
7. Client(s) agree(s) to update this agreement as requested by Walkersville Veterinary Clinic.

I/We certify that the foregoing information has been supplied truthfully, accurately and voluntarily. I/We have read completely Walkersville Veterinary Clinic's Payment Policy and understand and agree to all terms set forth in this agreement and to make payment promptly in accordance with these terms.

Signature: _____ Signature: _____
 (Client) (Joint Client)

CREDIT CARD TO BE HELD ON FILE:

 (Visa ___ Mastercard ___ Discover ___ American Express ___)

Expiration Date: _____

Authorization Signature: _____

Name on Card: _____

EQUINE INFORMATION

Location of horse(s) (Barn Name):

Name of Barn Manager: _____

Barn Manager's Phone: _____

Emergency Contact: _____

Phone: _____

Name of Horse: _____ Nickname: _____

Age: _____ Sex: _____ Coat Color: _____ Breed: _____

List any sensitivities to food or medication: _____

Pertinent health/behavioral concerns: _____

Additional Horses:

Name of Horse: _____ Nickname: _____

Age: _____ Sex: _____ Coat Color: _____ Breed: _____

List any sensitivities to food or medication: _____

Pertinent health/behavioral concerns: _____

Additional Horses:

Name of Horse: _____ Nickname: _____

Age: _____ Sex: _____ Coat Color: _____ Breed: _____

List any sensitivities to food or medication: _____

Pertinent health/behavioral concerns: _____

Name of Horse: _____ Nickname: _____

Age: _____ Sex: _____ Coat Color: _____ Breed: _____

List any sensitivities to food or medication: _____

Pertinent health/behavioral concerns: _____

Name of Horse: _____ Nickname: _____

Age: _____ Sex: _____ Coat Color: _____ Breed: _____

List any sensitivities to food or medication: _____

Pertinent health/behavioral concerns: _____

Name of Horse: _____ Nickname: _____

Age: _____ Sex: _____ Coat Color: _____ Breed: _____

List any sensitivities to food or medication: _____

Pertinent health/behavioral concerns: _____

OTHER LARGE ANIMAL INFORMATION

The animals to be seen by Walkersville Veterinary Clinic are: (Please circle yes and approximately how many)

Goats	Yes	_____
Sheep	Yes	_____
Pigs	Yes	_____
Cows	Yes	_____
Poultry	Yes	_____
Water fowl	Yes	_____
Rabbits	Yes	_____
Other (please describe)		_____
(how many)		_____

Please check the following for the animal(s) circled above:

Show animal(s) _____
Dairy animal(s) _____
Meat animal(s) _____
Pet(s) _____
Other (please state) _____

List any health concerns: _____

Other pertinent information: _____

