



P.O. Box 345 Bonner Springs, KS 66012
 Office: (913) 728-2499
 Fax: (913) 728-2232
 www.StrainEquineServices.com

VETERINARY SERVICES AGREEMENT

Thank you for retaining Strain Equine Services, LLC (“SES”) as your provider of Veterinary health services. This Agreement will govern the veterinary services we provide to the Horse Owner (“Client”) either directly or as approved by an authorized agent listed in this Agreement. This Agreement applies to all horses owned or leased by Client and applies to any and all veterinary services provided by SES, including but not limited to, in or out-patient services, procedures, medicines and farm call to any and all horses on Client’s behalf, whether or not the horse(s) is listed on page one of this Agreement

Horse Owner Information

Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Cell #: _____ Home#: _____
 Email: _____
 Last 4 digits of Social Security #: _____
 OR
 Driver’s License # _____ State: _____ Expiration Date: _____

Horse Information

Horse Name	Age	Breed	Use	Color	Gender

Stable: _____ Tel#: _____
 Insurance Company: _____ Tel#: _____
Authorized Agent:
 Name: _____ Tel#: _____

- I authorize my agent to make appointments and order medication for my horse(s) and give him/her permission to charge such appointments/medication to my credit card. Yes No
- I authorize the release of medical information about my horse(s) to my agent. Yes No
Failure to check or circle a preference will be deemed a “No” response

“Working hard to improve and maintain the health and performance of your equine.”

PLEASE SEE BACK SIDE

Strain Equine Services
P.O. Box 345 Bonner Springs, KS 66012
Office: (913) 728-2499
Fax: (913) 728-2232
www.StrainEquineServices.com

Referred by (if applicable): _____ **Tel#:** _____

Payment Policies

1. 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 notify SES
2. I understand that I must pay all accounts in full upon receipt of invoice and all hospital appointments must be paid prior to discharge.
3. Appointments must be cancelled or rescheduled at least 24 hours in advance of the appointment. If I am not able to comply with this policy, a cancellation fee will be applied to my account and I may be billed for any charges associated with any and all services or supplies utilized in preparation for the appointment.
4. Payment in full is required within 30 days of invoice for ambulatory calls and before discharge for all hospital appointments. If payment is not received within this time frame, I agree to settle my account by allowing SES to automatically charge the balance due to my credit card.
5. Late charges shall be applied to my account at a rate of 15% per year with a \$4 minimum per billing cycle for any invoices over 30 days
6. Should SES be forced to commence administrative and/or legal action to collect unpaid invoices from me:
 - a. I consent to personal jurisdiction of the courts of the State of Kansas
 - b. I agree to pay all costs, expenses and reasonable attorney's fees incurred by SES that are associated with such action
7. I agree to provide SES with current information and data regarding any changes in address, credit cards, or expiration dates, and SES is authorized to revise its records accordingly

Services (required – please Initial after each statement)

1. I hereby authorize SES to provide routine and emergency care to my horse(s) in my absence or at the request of my barn management/trainer/authorized agent _____
2. I authorize the use of appropriate sedation and/or other medication(s) and I understand that SES personnel will be utilized as deemed necessary by the attending veterinarian _____

By signing below, I agree that I have read, understand, and voluntarily agree to comply with the terms and conditions of the Agreement as a legally enforceable contract with Strain Equine Services, LLC. I further understand and agree that veterinary service cannot be provided without my initials where requested above and payment information provided below. If I decline to provide a credit card, 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.

Signatures Please Sign Below

Print Legal Owner's Name: _____
Owner's Signature: _____ **Date:** _____

(Facsimile signatures are deemed legal and enforceable in the state of Kansas)

Guardian's Name: (if Owner under 18 Years of Age): _____

(Account must be set up under both names if owner is under 18 years of age)

(Facsimile signatures are deemed legal and enforceable in the state of Kansas)

Guardian's Signature: _____ **Date:** _____

Credit Card Information

VISA MASTERCARD

CREDIT CARD#: _____ **Exp:** _____ **v-code** _____ (3 digits on back of card)

Name on Card: _____ **Authorized Signature:** _____

“Working hard to improve and maintain the health and performance of your equine.”