MISSION EQUINE HOSPITAL

New Client Intake Form

Owners Name (First and Last):_____

Address: _____
Street City State Zip code

Home Phone:_____ Cell Phone:_____

Email Address: _____

Payment Policy:

Payment is due when services are rendered. I certify Mission Equine Hospital to charge the below account for services rendered and also agree to pay for any and all collection fees and/or legal fees incurred on the below account.

Debit/Credit Cardholder Name:_____

Card No.:_____ Exp.: _____

Billing Zip Code:_____ Security Code: _____ **OR**

Care Credit Card No.:_____ Drivers Lic. No.: _____

Billing Zip Code:_____ Drivers Lic. Exp.: _____

Patient Information:

Horse's Name: _____ Age:_____

Breed: _____ Color: _____ Sex: _____

Medical History: _____

Current Problem: _____

Previously Treated for this condition: ☐ Yes ☐ No

Vaccination History Current: ☐ Yes ☐ No Known Drug Allergies:_____

Has the horse ever exhibited any unusual behaviors: puling back, kicking, wind sucking?

If so, please explain: _____

Horse's Diet: _____

Major Medical Insurance: ☐ Yes ☐ No Mortality: ☐ Yes ☐ No

Insurance Name: _____ Phone: _____

Adjuster's Name: _____ Phone: _____

I certify and warrant that I am the owner and/or owner's agent of the above animal or that I am responsible for it and have the authority to execute this consent to treatment. I hereby authorize the use of such anesthetics as you deem advisable and the performance of such surgical or therapeutic procedures as you determine to be necessary. I agree to indemnify and hold you harmless from and against any and all liability arising out of the performance of any of the procedures.

I understand that I am responsible for the payment of the charges associated with the care of this animal. In the event that I fail to comply with these terms, I authorize Mission Equine Hospital to charge the bill in its entirety to my card listed above. Should the account become delinquent, there will be a 3% service fee assessed to the outstanding balance.

Should it become necessary to utilize the services of a collection agency or attorney to collect this account, the undersigned agrees to pay all costs of collection, including attorney fees and expenses, court costs, and interest. This agreement is made and enter into Orange County, California. Jurisdiction and venue for all suits relative to treatment by Mission Equine Hospital of my horse(s) shall be Orange County, California.

Owner/Agent Signature_____ Date: _____

Printed Name: _____

31441 Avenida De La Vista, San Juan Capistrano, CA 92675 •(949) 661-2225 • office@missionequine.net