Patient Treatment Consent Form

Owners Name (First and Last):____

Address: ____
Street City State Zip code

Home Phone:_________________________ Cell Phone:________________________________

Email Address: _____________________________________

Horse's Name: ____ Age:__________

Breed: ________________________ Color: ________________________ Sex: ____________

Payment Policy:
Payment is due when services are rendered.

Debit/Credit Cardholder Name:____

Card No.:____ Exp.: ___________

Billing Zip Code:____________________ **OR**

Care Credit Card No.:__________________________________ Drivers Lic. No.: ___________

Billing Zip Code:____________________ Drivers Lic. Exp.: __________

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 an 18% APR (1.5% monthly) 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 Signautre____ Date: __________

Printed Name: ____