EQUINE MEDICAL CENTER OF CLEVELAND, LLC

Surgery, Medicine & Reproduction

Scott Williams, DVM
Arlynn Blazer, DVM

WELCOME

665 Urbane Road
Cleveland, TN 37312
Clinic (423) 559-9690
Fax (423) 559-8492

Thank you for giving us the opportunity to care for your pet. To insure the best possible care, please take the time to fill out this form completely.

Name _____ **Spouse/Other**_____

Address _____ **City** _____ **State** ____ **Zip** _____

Home Phone _____ **Cell** _____ **Spouse/Other** _____

Employer _____ **Work Phone** _____

Stable/Farm Name _____ **Stable Phone** _____

Social Security # or Driver license # _____

Were you referred by someone? _____

Email Address _____

Do you wish to receive emails from Equine Medical Center? Y N

The primary concern of our clinic is the care and treatment of our patients. In order to provide this professional care, we must establish the following policy:

1. **Payment is required in full at the time services are rendered.**
2. **Payment must be established before services are rendered. Method of payment can be in the form of cash, check, Visa, MasterCard, Discover, or American Express.**
3. **A $35.00 service fee will be charged for all returned checks.**
4. **Accounts over 30 days will be charged an interest fee of 1.5% monthly.**
5. **Accounts requiring legal/collection action will be responsible for collection costs and reasonable attorney fees.**
6. **In addition to the regular charges, an emergency fee of $80.00 will be added to all after hours and emergency cases.**

I HEREBY AUTHORIZE THE VETERINARIAN TO EXAMINE, PRESCRIBE FOR, OR TREAT MY PET. I HAVE READ AND FULLY UNDERSTAND THE ABOVE POLICY AND AGREE TO THE TERMS STATED.

Signature _____ **Date** _____

I give Equine Medical Center of Cleveland, LLC permission to charge all services, medications and service charges to:

Credit Card # _____ **EXP** _____ **V-Code** _____

Signature _____ **Date** _____