

Juliea McCall, DVM

Veterinary Service Agreement

Client Information

Name: _____

Address: _____

City/ State/ Zip: _____

Phone: Home or Work # _____ Mobile Phone # _____

Email: _____

Name of person authorized as agent for veterinary care & contact number:

Patient Information

Horse's Name	Age	Colour	Breed	M/G/S
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Horses Stabled at: _____

Trainer (if applicable): _____

Farrier: _____

Primary Care Veterinarian: _____

Acknowledgement of Veterinary Services:

Please initial after each statement

I authorize Juliaa McCall, DVM to provide Chiropractic, Acupuncture, and basic medical care for my horse. Although this may include some emergency medicine during regular business hours, I understand that Juliaa McCall, DVM does not offer after hours emergency service. I understand that I am encouraged to maintain a relationship with my primary care veterinarian who can provide after hours emergency service. _____

I authorize Dr. McCall to communicate with my primary care veterinarian regarding my horse's medical record and care. _____

I authorize Dr. McCall to communicate with my farrier regarding my horse's medical record and care. _____

I understand that payment for veterinary medical care is due at the time of service, and can be received as cash, check, or credit card. _____

I understand that a valid credit card is required to be on file with the office in order to activate a client account with Juliaa McCall, DVM. _____

I prefer to receive mailed communications (statements, medical reports) as necessary via email _____ U.S. Postal Service _____ or both _____
I can change this preference at any time by contacting the office _____

CC # _____ Exp : _____ Security Code: _____

Name on Credit Card: _____

Signature: _____ Date: _____