GULF COAST
EQUINE HOSPITAL
251-989-4234

CLIENT FORM

Owners Name: _____

Address: _____

City:_____ State:_____ Zip:_____

Home phone:_____ Cell phone:_____

Employer:_____ Work phone:_____

Drivers License State/# _____

Email:_____

Horse(s) Name, Breed, Age, Sex, and Color

1.)

2.)

3.)

4.)

5.)

All fees are due at the time the patient is released. On your request we will provide you with a written estimate of fees before any case, hospital treatment, emergency care, surgery, or hospitalization will be provided. A deposit prior to treatment may be required depending on the amount of the estimate.

I/We agree that if our balance becomes delinquent, defined as 90 days past due, and is referred to a collection agency or attorney, we shall be responsible for collection fees equal to 33 1/3% of the balance due in addition to the balance. We further understand and agree that if legal action is taken to collect the balance, we shall also be responsible for all court costs. We hereby waive our rights under the laws and constitution of Alabama, to exempt our real or personal property from execution. (initial)

In the event my account becomes more than sixty days past due, I authorize Gulf Coast Equine Hospital and any of its officers, agents or employees, to request my credit report. I also understand any past due balances may be reported to one or all of the national credit bureaus. I also authorize Gulf Coast Equine Hospital and any of its officers, agents or employees to contact me by phone, cell phone, "Text Message," E-mail or any other universally used modes of communications as needed to confirm appointments, provide essential treatment information or secure payment of outstanding past due balances.

Owner's Signature _____ Date:_____

Payment Information for card to be kept file:

Credit Card #:_____

CVV:_____

Expiration Date: _____