SCOTT EQUINE SERVICES

Client Information Form

Name: _____
Spouse: _____
Address: _____
City: _____ State: _____ Zip: _____
Driver's License #: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ E-mail: _____
Employer: _____
Address: _____
City: _____ State: _____ Zip: _____

Emergency Contact: _____ Phone: _____

How would you prefer to receive your statements? (Circle one) **E-mail USPS**

Who may we thank for referring you to our practice? _____

Full payment is due at time of service. We require a credit card held on file to secure all accounts. I, the undersigned, do promise to pay for any and all veterinary services rendered by Dr. Robert Scott or his associates for the veterinary care of my animal(s). I understand that my account will be considered past due and a service charge of 1 1/2% ($5.00 minimum) assessed to my account after 30 days. I understand that in the event of collection, I am responsible for all costs including but not limited to interest, collection agency fees, court costs and legal fees. I authorize his practice to charge off in full to my credit card ending in: _____ Exp: _____ any balance that is 30 days past due.

_____ **Automatic payment** (*Initial*). Charge my credit card for my balance in full every billing cycle and send me a receipt.

Signature **Date**

(to be destroyed)

Credit Card #: _____
Expiration: _____ CIV: _____

www.scottequine.com
1909 SE 4th Avenue; Fort Lauderdale, FL 33316
Office: (954) 252-9744 Fax: (954) 252-9757 E-mail: office@scottequine.com