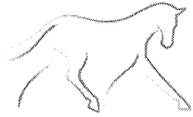


Kopec Veterinary Associates, P.C.

24 Hour Mobile Equine Service And Haul In Facility

400 Stackstown Road, Marietta PA 17547
717-361-8700, 717-361-8708 fax
kvaequine@gmail.com

HOSPITAL ADMISSION AGREEMENT AND CONSENT

I, the undersigned, do hereby certify that I am the owner, leasee and/or agent of the animal identified herein and that I hereby authorize Kopec Veterinary Associates to evaluate, assess, treat and/or perform procedures (breeding, surgical, medical) which are deemed necessary by the attending veterinarian.

I further authorize and certify that the nature and performance of procedures medical or surgical, identifiable alternative methods, and treatments carry certain risks and possible complications. These have been fully explained to me and are understood by me. I also recognize there are no guarantees or assurances for 100% success with any reproductive, medical or surgical procedure.

PAYMENT POLICY

I (the owner or duly authorized agent thereof) agree to accept responsibility for full payment of all breeding, treatments, surgeries and/or services rendered by Kopec Veterinary Associates, regardless of the accuracy of the fee approximation shown.

I agree to pay a deposit of no less than 50% of the initial fee estimate when the horse is admitted to Kopec Veterinary Associates. I agree to pay the balance of the fees due before the release of the horse from Kopec Veterinary Associates.

If other financial arrangements are needed, I will contact the office manager of Kopec Veterinary Associates (phone 717-361-8700) prior to bringing the horse to Kopec Veterinary Associates. We accept cash, personal checks, money orders, Visa, MasterCard, Discover, AMEX and CareCredit.

If it is necessary to bring an action to compel the payment of fees or costs, the undersigned shall pay all costs incurred in collection of the debt and reasonable attorney fees.

The initial fee estimate is $____________________. The owner/agent will be contacted if the charges go beyond this agreed upon amount.

ADMITTANCE-VISITING-DISCHARGE POLICY

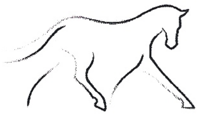
I understand that no horse will be brought to Kopec Veterinary Associates without prior agreement as to time and date.

I understand that I may be able to visit my horse at Kopec Veterinary Associates between the hours of 8:00am and 4:00pm Monday-Friday or by other arrangements.

I understand that no horse will be discharged from Kopec Veterinary Associates without prior agreement as to time and date.

I hereby state that I have read and understood this authorization and release and acknowledge receipt of a copy thereof. If signing as agent of the owner, the undersigned warrants that he/she has authority to bond the owner. I acknowledge that I have been informed that fees for the treatment that may be rendered to this animal are approximate.

OWNER/AGENT:______________________________ DATE:______________
PRINTED NAME:______________________ EMERGENCY CONTACT #:________________
PATIENT:______________________



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PATIENT ADMISSION FORM

Patient Name:____________________
Owner Name:____________________
Contact #:____________________

Feeding Instructions

Feed: *Product*____________________ *Amount*____________________ Hay:____________________

Medication (s):______________________________ Supplements:____________________

Vices

Kicks ☐Yes ☐No   Bites ☐Yes ☐No   Cribs ☐Yes ☐No   Other:____________________

Insurance Information

Is your horse insured? ☐Yes ☐No

If yes, Insurance Company's Name and Number______________________________

Drug Allergies

Does your horse have drug allergies or reactions? ☐Yes ☐No if yes, explain____________________

Patient History

Vaccination	Date Last Vaccinated	Vaccinate during Stay?
E,W Tetanus		☐ Yes ☐ No
West Nile		☐ Yes ☐ No
Rabies		☐ Yes ☐ No
Influenza		☐ Yes ☐ No
Rhinopneumonitis		☐ Yes ☐ No
Potomac Horse Fever		☐ Yes ☐ No
Botulism		☐ Yes ☐ No
Other:		☐ Yes ☐ No
Coggins Test	Date Last Tested:	Draw during stay? ☐ Yes ☐ No

Deworming History

Date Last Dewormed: ____________________

Product Used: ____________________

Fecal Testing During Stay: ☐ Yes ☐ No

Date Last Trimmed: ____________________

Equipment/Tack/Feed:

____
____
____

Brian Kopec, D.V.M.
Molly C. Kopec, D.V.M.

Heather M. Crather, D.V.M.
Jessica Benson, D.V.M.

Kopec Veterinary Associates, P.C.

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Credit Card Payment Authorization Form

Payment is due in full at the time of service. Please sign and complete this form to authorize Kopec Veterinary Associates to make a debit to your credit card listed below.

By signing this form you give us permission to debit your account for the amount indicated on or after the indicated date.

Kopec Veterinary Associates requires ALL out of state clients to have a credit card on file for services rendered.

Please complete the information below: **Amount: $____________**

Your completion of this section of this authorization form helps us to protect you, our valued client, from credit card fraud. All information entered on this form will be keyed into a completely secure credit card vault whereby the card information will be encrypted and tokenized. What this means to you is, our staff will no longer have visibility to your full credit card information after it is secured. When an invoice is due to be paid, we will be able to charge "the card on file" without keying in the number again.

Account Type: ☐ Visa ☐ MasterCard ☐ Discover ☐ AMEX ☐ CareCredit**

Cardholder Name: ________________________________

Card Number: ____________________________ Exp Date:____/____ CVV#: ______

Billing Address(If different):______________________ Phone#:____________

City, State, Zip: ________________________ Email:____________

****Please select a payment option: (If no option is selected – Full account balance will be charged)***

☐ ONE TIME USE ONLY

☐ KEEP CARD ON FILE FOR FUTURE USE

(Any balance over 30 days will automatically be charged to the card)

☐ AUTOMATICALLY CHARGE CARD FOR ALL SERVICES

(I understand my card may be charged for services without prior notification to me)

*****CARECREDIT ONLY:*** Drivers license or another form of ID is required for ***CareCredit*** transactions if no expiration date or CVV available.

ID Exp Date:____/____ State: ______ *(Forms of ID: Drivers License, Military ID, Photo ID etc)*

AUTHORIZED SIGNATURE ______________________ DATE ____________

I authorize Kopec Veterinary Associates to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above, for the amount indicated above or to keep the credit card on file with Kopec Veterinary Associates. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

THIS FORM WILL BE DESTROYED ONCE CREDIT CARD INFORMATION IS ENTERED