Kopec Veterinary Associates
24 Hour Mobile Equine Service And Haul In Facility

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

VETERINARY SERVICES CONTRACT

Please Note: *By signing this document, you are forming a contract with KOPEC VETERINARY ASSOCIATES. This contract creates certain rights and obligations including, but not limited to, those described on the third page of this contract.* ***Payment is required at the time of service****. Insurance claim payments for a major medical claim will be sent to you directly from your insurance company.*

OWNER INFORMATION-

NAME:_____ **SPOUSE:**_____

ADDRESS:_____

CITY:_____ **STATE:**_____ **ZIP:**_____

Same as shipping address? □ YES □ NO - If No, address:_____

HOME PHONE:_____ **CELL:**_____

E-MAIL:_____ **PREFERRED CONTACT METHOD:**_____

EMPLOYER NAME:_____ **WORK PHONE:**_____

STABLE INFORMATION- ***Same as owner address? □ YES □ NO - If No, complete this section.***

STABLE NAME: _____

CONTACT NAME:(barn owner, agent, manager)_____

ADDRESS: _____

CITY: _____ **STATE:**_____ **ZIP:**_____

PHONE: (barn number) _____ **CELL:**_____

E-MAIL: _____ **WEBSITE:**_____

I authorize the release of medical information about my horse(s) to my barn manager/agent.
□ Yes □ No

I authorize my barn manager to act as agent to make appointments and order medication for my horse(s):
□ Yes □ No

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HORSE INFORMATION— ***Do you*** **□** ***Own or*** **□** ***Lease this horse?***

REGISTERED NAME:_____

BARN (call) NAME:_____

DATE OF BIRTH/AGE:_____ **BREED:**_____

COLOR(S):_____**GENDER: □ MARE □ GELDING □ STALLION**

Registration #:_____**Tattoo#:**_____
Brands:_____ **Microchip#:**_____

Is this horse insured? **□ NO □ YES If *yes*, please complete the insurance information below.**

INSURANCE COMPANY NAME: _____

PHONE: _____**POLICY #:**_____

Does this horse have multiple owners: □ NO □ YES

Additional owner contact information if applicable: _____

Has this horse ever been treated previously by our clinic? □ NO □ YES

In case of emergency, notify:_____**Phone:**_____

RELEVANT MEDICAL HISTORY (ex. Colic, Cushings) _____

Medications:_____ **Supplements:**_____

BREEDING HISTORY(if any):_____

VACCINE HISTORY: **Vaccine and medical records can be attached from previous veterinarian**

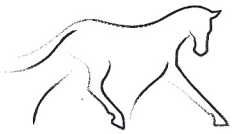
□ ***E/W Enceph Tetanus*** **—Date:**_____ **□** ***West Nile*** **— Date:**_____
□ ***Rhino/Flu*** **— Date:**_____ **□** ***Rabies*** **— Date:**_____
□ ***Potomac*** **— Date:**_____ **□** ***Strangles*** **— Date :**_____
□ ***Botulism*** **— Date:**_____ **□** ***Other*****:**_____

Coggins testing: □ NO □ YES Date:_____ **Please attach a current copy**

DEWORMING HISTORY: Product: _____**Date:**_____

FECAL TESTING: Date:_____ **Results:**_____

Additional Information: _____
Multiple horses? This page can be printed and submitted for each horse.



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ACCOUNT INFORMATION **Required-please initial after each statement**

1. I understand that I must pay all accounts in full at the time of service and all hospital stays must be paid before discharge. Initial_____

2. I hereby authorize Kopec Veterinary Associates, to provide routine and emergency care to my horse(s) in my absence or at the request of my barn management trainer/agent.
   □Yes □ No Initial:_____

3. This contract shall apply to any and all veterinary services provided by Kopec Veterinary Associates, including but not limited to out-patient services, procedures, medi cations and farm calls to any and all horses on your behalf, whether or not the horse(s) are listed on page two of this form. Initial:_____

4. I would like to receive my invoices/statements via email. □Yes □ No Initial:_____

5. Late charges shall be applied to all accounts overdue at a rate of 1.5% monthly. Initial:_____

6. Should Kopec Veterinary Associates be forced to commence administrative and/or legal action to collect unpaid invoices from you:

   a. You consent to personal jurisdiction of the courts of the State of Pennsylvania. Initial:_____

   b. You agree to pay all costs, expenses and reasonable attorney's fees incurred by Kopec Veterinary Associates, that are associated with such action. Initial:_____

7. You represent that you are presently able to comply with the payment terms herein, and that if you should become unable to make timely payment of outstanding invoices, you will contact Kopec Veterinary Associates. Initial:_____

****VETERINARY SERVICES WILL NOT BE PROVIDED WITHOUT YOUR INITIALS (above) AND SIGNATURE (below)*****

NAME (PRINT):
SIGNATURE:
DATE:

KOPEC VETERINARY
ASSOCIATES, P.C.

Kopec Veterinary Associates, P.C.

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Marietta, PA 17547
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www.kvaequine.com
kvaequine@gmail.com

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