1202 Calle Maria
San Marcos, California
92069
E-mail: sdequinegroup@sdequine.com
www.sdequine.com

Phone- 760-591-9952
Fax- 760-591-9977

Client Information and Authorization

Please complete all fields. This document must be completed, in its entirety, in order to schedule an appointment with San Dieguito Equine Group. This release authorizes us to provide veterinary care and allows you to inform us of anything that you do not authorize. It also gives you the opportunity to let us know who is authorized to make important medical decisions for your horse(s) on your behalf.

Your Information:

Name: ____

Address: ____

Phone: ____________________________ (cell) _______________________________ (other)

Email: ____

Authorized Representatives:

I authorize the following people to make treatment decisions and/or request medications and supplements my horse(s):

1. Name____ Relationship_______________

Phone: ____

2. Name____ Relationship_______________

Phone: ____

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Horse(s) Information:

1. Horse (Barn and Show Name):____

Breed: _________________ Color: ___________ Age: ____________ Sex: ____________

Use: ____________________________Boarding location: ______________________________

Allergies or Special Concerns: ____

Trainer: ________________________ Phone: _____________________

I authorize my trainer to make treatment decisions and order medications/supplements for the above listed horse in my absence ____ (initial)

If insured, please complete the following:

Company: ____

Policy Number: ________________________________ Phone: __________________

2. Horse (Barn and Show Name):____

Breed: _________________ Color: ___________ Age: ____________ Sex: ____________

Use: ____________________________Boarding location: ______________________________

Allergies or Special Concerns: ____

Trainer: ________________________ Phone: _____________________

I authorize my trainer to make treatment decisions and order medications/supplements for the above listed horse in my absence ____ (initial)

If insured, please complete the following:

Company: ____

Policy Number: ________________________________ Phone: __________________

(Please contact the office if you need to add additional horses.)

I understand that it is my responsibility to notify the office in writing if there are any changes to the ownership/financial responsibility of any of the above listed horses. _____ (initial)

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Referral:

I understand that my authorized representatives, listed above, may authorize referral to a secondary facility for emergency medical treatment or surgery if the doctor(s) at San Dieguito Equine Group conclude, in their professional opinion(s), that my horse may benefit from this emergency referral. _______ *(initial)*

I understand that many referral facilities will not admit patients without a deposit or a payment made by me or my authorized representative(s). _______ *(initial)*

It is my responsibility to make arrangements with my authorized representative(s) in advance for this type of situation. _______ *(initial)*

I understand that any charges from a referral facility will be in addition to and separate from those with San Dieguito Equine Group. _______ *(initial)*

I understand that it is my responsibility to arrange for transportation to and from an emergency medical facility. _______ (*initial)*

Acknowledgement and Authorization:

I, (please print) ____, declare that I am the owner or responsible party of the horse(s) described above. I have authority to execute this consent and am over the age of 18 years old. I hereby authorize and direct the veterinarians of San Dieguito Equine Group to perform the necessary procedures on my horse(s) as outlined above. I understand that some risks always exist with any procedure and that I am encouraged to discuss any concerns I have in regards to those risks with the veterinarian(s) before any procedure begins. I have thoroughly read and fully understand this consent form.

Signature: ____ Date: _____________

Notes or additional comments: ____

____

____

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Payment Agreement:

I understand that payment for all services rendered is due within 30 days, any invoices incurred are my responsibility (including those requested by my authorized representatives), and nonpayment for services will result in 1.5% monthly service charge. _______ *(initial)*

SDEG requires clients to have a credit card on file to establish an account. Credit card information is stored on a secure site that meets the highest compliance standards for financial security and processing. _______ *(initial)*

Please choose one of the following payment options:

Recurring credit card payment: Please enroll me in the Preferred Client Discount Program. I understand that this program entitles me to receive a 21% discount on all administered/dispensed medications and supplies. I understand that by enrolling in this program, my credit card will be charged without prior notification to me monthly, in full, for total accrued charges. I understand I will receive a monthly statement but no further action will be required. I understand cancellation of this program must be in writing. _______ *(initial to select)*

I would like to use an alternative form of payment. If an alternative form of payment is not received within 30 days of the billing date, I authorize SDEG to bill my credit card for any outstanding balances. _______ *(initial to select)*

Accepted forms of payment include cash, check, and all major credit cards. Unless otherwise requested, all statements/invoices will be sent electronically.

I have read and understand the terms and conditions and I agree to pay for all services rendered.

Date: _______________ Signature: ____

American Express / MasterCard / Visa / Discover

Credit Card #: ____ Exp: _______CVV: _______