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CLIENT ACCOUNT & BILLING INFORMATION

Owner Name:		Owner Name:	
Mailing Address:			
City, State, Zip Code:			
Phone : Home	Phone: Work		Phone: Mobile
Email:			
Credit Card Type:	Expiration Date:		CVV Code:
Credit Card Number:		Name on Card:	
Credit Card Billing Address (if different from above):		Credit Card Signature:	

****The above referenced credit card will be charged monthly (on the 20th) for any and all statement balances****

- ☐ Automatically charge my credit card for services and email my receipt.
- ☐ I would like my invoice and/or statements to be emailed to me at the referenced email address.
- ☐ I would like to receive the Mission Equine Associates email newsletter.

Please read the following IMPORTANT INFORMATION:

I assume responsibility for all charges incurred in the care of my animal(s). I understand that all charges must be paid in full at the time of service. All past due balances will be assessed a monthly service fee of 1.5%. I authorize the above credit card to be charged for the full balance if not paid by the 20th of the month. Legal and collection fees are the responsibility of billed party, regardless of payment arrangements.

Authorized Signature:	Date:
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HORSE LOCATION INFORMATION

Barn Name:
Barn Address : (if different from above):

*****I authorize my rep. (Name) _____ to request veterinary examination, treatment, or medication on my behalf and I promise to pay for all charges that may occur under this authorized individual. Initial _____***

Horse Name	Nickname	DOB/Age	Sex	Color	Breed