

Date: _____

Wilhite & Frees
Equine Hospital



Client Information

Name		
Address		
City	St	Zip
Home Phone	Cell Phone	
E-Mail		
Would you like to receive information regarding your horses' health via e-mail?		
How did you hear about our hospital?		
Who, other than yourself, is authorized to request medical treatments for your horse (please list name and contact number)?		

Payment Policy

1. Payment is required at the time of service. If you are not available, it is important that we have current credit card information on file.
2. A \$35 service charge will be assessed for any returned check.
3. A 1.75% (21% annual) monthly service charge will be added to accounts 30 days past due. A \$5.00 minimum applies monthly.
4. Any account 60 days past due will be referred to a collection firm for handling. The client will be responsible for any additional collection charges incurred.
5. We will have no option but to discontinue further veterinary services for any account that is 90 days past due, unless special arrangements are made in advance.

Authorization

I hereby authorize Wilhite & Frees Equine Hospital to examine, prescribe for, or treat the described patient. I assume responsibility for all charges incurred in the care of this horse and provide appropriate payment information below. I understand that this responsibility will include any legal and/or collection expenses that may be necessary in the event that services are not paid for.

Method of payment ___ Check ___ Cash ___ Credit Card (Visa, Mastercard, AmericanExpress, Discover) ___ Care Credit

Type of Card: _____ Card # _____ Exp _____

Signature of Legal Owner or Agent _____ **Date** _____

P-816-779-0100
F-816-779-0161
wilhiteandfreesequine@comcast.net
www.wilhiteandfrees.com

PO Box 425
21215 S Peculiar Dr
Peculiar, MO 64078



Patient Information

Patient's Registered Name	Patient's Barn Name
Breed	Date of Birth/Age
Sex	Color
Is horse insured?	If yes, with who?
Where is patient stabled?	
Vaccination/Medical History: Please list the date horse last received the following vaccinations:	
Eastern/Western Encephalomyelitis	West Nile
Tetanus	Rhino/Flu
Strangles	Rabies
Other vaccinations	Date of last Coggins test
When was horse last dewormed?	What product was horse dewormed with
Does horse have any medical conditions we should be aware of (HYPP, EPM, etc)?	

Patient Information

Patient's Registered Name	Patient's Barn Name
Breed	Date of Birth/Age
Sex	Color
Is horse insured?	If yes, with who?
Where is patient stabled?	
Vaccination/Medical History: Please list the date horse last received the following vaccinations:	
Eastern/Western Encephalomyelitis	West Nile
Tetanus	Rhino/Flu
Strangles	Rabies
Other vaccinations	Date of last Coggins test
When was horse last dewormed?	What product was horse dewormed with
Does horse have any medical conditions we should be aware of (HYPP, EPM, etc)?	

P-816-779-0100
F-816-779-0161
wilhiteandfreesequine@comcast.net
www.wilhiteandfrees.com

PO Box 425
21215 S Peculiar Dr
Peculiar, MO 64078