



80 Kenney Rd.
New Ipswich NH 03071
978-302-7983

AUTHORIZATION FOR PROFESSIONAL SERVICES

Client/Owner Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: Cell: _____ Home: _____ Work: _____

Email: _____

Horse Stabled at: _____

Authorized Agent: _____

Horse/Animal Description

Species	Name	Age	Breed	Sex	Color

Please fill out reverse side of page

1. I hereby authorize the doctors at McGee Equine Clinic to perform any and all veterinary services to any and all animals on your behalf, whether or not the animal(s) are listed on the first page of this form. I understand that such treatment may include the administration of vaccines, medications, rectal palpation and ultrasound examinations, diagnostic radiology, dentistry, and other tests, surgical procedures, anesthetics or treatments that the veterinarians deem necessary for the health, safety, or well-being of the horse/animal.

2. I acknowledge that I have been informed of the nature and character of the proposed treatment, of the anticipated results of such efforts, and of possible alternative forms of treatment. I have also been informed of any recognized, serious potential risks or complications, and of the anticipated benefits involved in the proposed or alternate treatments, including non-treatment. I understand that there is no guarantee or warranty as to a result or a procedure and that, as in any medical or surgical treatment plan, undesirable results including death may be attendant to the performance of any procedure.

3. I agree to indemnify and hold McGee Equine Clinic harmless from and against any and all liability arising out of the performance of any of the procedures referred to above as well as any losses or injuries due to care, custody, or handling.

4. **Payment is due in full when services are rendered.** In the event that I default in the payment of any amounts owed to McGee Equine Clinic, I agree that I shall pay all costs of collection, including reasonable attorney fees, incurred by McGee Equine Clinic as a result of my default in payment, and that such costs of collection shall be added to my account balance and become my responsibility, whether or not a lawsuit is filed in Court to collect any delinquent balance owed by me. If legal action is necessary to collect unpaid invoices all costs of collection shall be charged to debtor. I agree that McGee Equine Clinic shall recover its costs, including reasonable attorney's fees, incurred in the enforcement hereof (and collection of sums owed) in addition to any other remedies to which it may be entitled. A \$35.00 service charge will be added for any returned check. We will not redeposit the check. I understand that if payment is not received in full at the time of service, each monthly statement that is sent to me will be subject to a \$15.00 billing fee. I understand that a late fee of 1.5% per month or 18% annually will be applied to all accounts more than 30 days past due.

5. If I am not the owner, I affirmatively represent and warrant to the McGee Equine Clinic that I am the Authorized Agent of the Owner and that I possess complete power and authority and am fully authorized by the Owner to seek medical treatment for the horse/animal described above and to complete this form on the Owner's behalf, in the Owner's place and stead.

I have read and understand this authorization and consent.

Dated: _____

(Signature of Authorized Agent/Owner)

Please fill out reverse side of page