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NEW CLIENT & PATIENT ACCOUNT INFORMATION

Payment Due When Services Rendered

Date: _____

Owner's Name: _____; Spouse: _____

Address _____
Street City State Zip Code County

Home Phone _____ Cell Phone _____; Work Phone: _____

Spouse Cell Phone: _____; Spouse Work Phone _____

Email: _____

Would you like to receive statements/reminders by email? Yes [] No []

Patient Information

Patient's Registered Name: _____; Barn Name: _____

Breed: _____; Age: _____; Sex: _____; Description : _____

Is Patient Insured: _____; If so, Agency Name: _____;

Contact Phone No: _____; Policy No.: _____

(If insured please note that payment is due at the time of service not when claims are settled)

Present Feed Schedule: List brand and quantity _____

Please list any supplies you are leaving _____

*Please note that we will not be held responsible for personal belongings left.

Current Coggins: Yes [] No []; Lab # _____; Date Drawn: _____

If no, one will be drawn.

Please list any information you would like updated:

Teeth _____ Vaccinations (please list) _____

Fecal _____ Deworming _____ Product Used _____ Other _____

(SEE NEXT PAGE PLEASE)

Medical History

Has this horse been treated with any medication (joint injections, oral, intramuscular or intravenous) within the last week? Yes No ; If yes, please explain

Is this horse allergic to any medications? Yes No ; If yes, please list _____

Payment Policy

Full payment is due when service is rendered. We accept cash, check, debit or credit cards.

* A \$30.00 Service Charge will be assessed for returned checks. *

A credit/debit card number on file is required to establish an account at Franklin Equine Services, LLC.

Please indicate your choice of payment below:

Cash: _____; Check: _____; Credit / Debit Card: _____

Name on Card: _____; Card Number: _____;

Exp. Date: _____; CCV: _____

Treatment Consent

I certify and warrant that I am the owner and/or owner’s agent of the listed horse. I am responsible and have the authority to execute this Treatment Consent. I hereby authorize Franklin Equine Services, LLC to perform any necessary procedures (including but not limited to vaccinations, medications, tests, surgical procedures, anesthetics or treatments) the doctor deems necessary for the health, safety and well being of the horse while it is under their supervisory care. No further consents are required for treatment of this animal.

I fully understand that I am giving Franklin Equine Services, LLC permission to treat this animal as it deems necessary in the best interest of the animal. I agree to indemnify and hold Franklin Equine Services, LLC harmless from and against any and all liability arising out of the performance of these procedures while this animal is in their care.

Responsible Party

I understand that I am responsible for the payment of the charges associated with the care of this animal. In the event I fail to comply with these terms, I authorize Franklin Equine Services, LLC to charge the bill in it’s entirety to my card listed above. Should the account become delinquent, there will an 18% APR (1.5% monthly) assessed to the outstanding balance.

Should it become necessary to utilize the services of a collection agency or attorney to collect this account, the undersigned agrees to pay all costs of collection, including attorney fees and expenses, court costs, and interest.

Undersigned states that he/she has read this document and fully understands the content hereof.

_____ Date: _____

Printed Name: _____

Signature of owner/agent