



## PATIENT AND CLIENT INFORMATION SHEET

**MYHRE EQUINE CLINIC 100 Ten Rod Road Po Box 1673 Rochester, NH 03866**  
**Phone: 603-335-4777 Fax: 603-335-9923 Email: [myhreequine@gmail.com](mailto:myhreequine@gmail.com)**

### CLIENT INFORMATION:

Today's Date: \_\_\_\_\_

Owner(s): \_\_\_\_\_ Spouse: \_\_\_\_\_

Last First MI

Address: \_\_\_\_\_

Street City State Zip Code

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Email Address \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

Trainer/Agent: \_\_\_\_\_ Trainer/Agent Phone: \_\_\_\_\_

Farrier: \_\_\_\_\_ Phone/Address: \_\_\_\_\_

rDVM: \_\_\_\_\_ Practice/Hospital: \_\_\_\_\_

rDVM Phone: \_\_\_\_\_ Address: \_\_\_\_\_

Is Patient Insured? \_\_\_\_\_ If yes, Company: \_\_\_\_\_

Surgical Insurance? \_\_\_\_\_ Mortality Insurance? \_\_\_\_\_

Please inform your insurance company that your horse has been admitted. We will complete the necessary forms when received and your insurance company will reimburse you for your payment to Myhre Equine Clinic.

Supplies Left: \_\_\_\_\_ (Please leave as few supplies as possible)

Leaving Trailer? \_\_\_\_\_ If yes, Make, Model, License Plate #: \_\_\_\_\_

**(Please note: We will not be held responsible for any personal belongings left at the clinic)**

### PATIENT INFORMATION:

Patient's Full Name: \_\_\_\_\_ Nickname: \_\_\_\_\_ Weight: \_\_\_\_\_ Patient ID #: \_\_\_\_\_

Age: \_\_\_\_\_ Breed: \_\_\_\_\_ Sex: \_\_\_\_\_ Color/Markings: \_\_\_\_\_

Present Feed Schedule (Please list brand and quantity): \_\_\_\_\_

Current Coggins (within 6 months): \_\_\_\_\_ Accession Number: \_\_\_\_\_ Date Drawn: \_\_\_\_\_

**(If not, in accordance with NH law, one will be drawn within 24 hours of admission)**

Hospital Visiting Hours: Monday – Friday 10:00 AM – 4:00 PM  
Saturday – Sunday 9:00 AM – 12:00 PM (Please Call Prior)

**TREATMENT:**

I am the owner of the above named animal or am responsible for it and have the authority to execute this consent.

I hereby authorize the performance of the following procedure(s): \_\_\_\_\_

I hereby also authorize the use of anesthetics as you deem advisable and performances of such surgical or therapeutic procedures as you determine necessary. I understand that general anesthesia represents an inherent risk. I agree to indemnify and hold you harmless from and against any and all liability arising out of the performance of any of the procedures referred to above.

\_\_\_\_\_  
\*Signature of Owner or Authorized Agent

\_\_\_\_\_  
Date

**PAYMENT POLICY:**

CASH, CHECK, OR CREDIT CARD DEPOSIT OF LOWER END OF ESTIMATE IS REQUIRED UPON ADMITTANCE. FULL PAYMENT IS REQUIRED UPON DISCHARGE.

**IF YOU PREFER A MONTHLY PAYMENT PLAN** we offer a Monthly Payment Plan Program through Med Choice. Med Choice, veterinary card, provides flexible payment arrangements that enable owners to spread cost of veterinary care over several months. Please call and ask about our Med Choice application.

The estimated cost of this procedure is \$ \_\_\_\_\_ (This estimate can be affected by complications or indications of unforeseen additional treatment or length of stay).

The estimated cost of Nuclear Scan is \$ \_\_\_\_\_ (Post-scan diagnostics and procedures can be as much as or more than the scan estimate itself).

Please indicate your choice of payment below:

Cash: \_\_\_\_\_

Check: \_\_\_\_\_ Drivers License #: \_\_\_\_\_ SSN: \_\_\_\_\_

A \$30.00 service charge will be assessed for any returned check. We will not redeposit the check. Your credit card will be charged for the outstanding balance.

Credit Card: \_\_\_\_\_ Card #: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Cardholders Name: \_\_\_\_\_ Billing Zip Code of Card: \_\_\_\_\_

Client agrees that payment is due upon discharge of the patient. Any unpaid balance will be charged to the credit card on file. Unpaid balances will be subject to interest at the rate of 24% per year (2% per month) until such unpaid amount is paid in full. Additionally, the client will be responsible for the reasonable cost of collection of any such unpaid amounts, including collection and attorney's fees.

\_\_\_\_\_  
\*Signature of Owner or Authorized Agent

\_\_\_\_\_  
Date

**Grant D. Myhre, DVM   Ron Vin, DVM, DACVIM (LAM)   Anne Schwartz, DVM Dipl ACVS**