HIGH WATER
VETERINARY SERVICES, LLC

2026 Client/Patient Form
PO Box 693
Norwalk, Ohio 44857
(419) 577-9060
HighWaterVet@gmail.com

Owner's Name_____ E-mail_____
Secondary Person's Name_____ Secondary E-mail_____
Driver's License # (required)_____ Owner DOB_____
Home Address_____
City_____ State_____ Zip_____ County_____
Primary Phone # (Specify Land-line or Cell)_____
Secondary Phone # (Specify Land-Line or Cell)_____

Address/location of Horse(s):_____

Name_____ Name_____
Reg. Name_____ Reg. Name_____
Breed_____ Breed_____
Sex_____ Sex_____
Color_____ DOB/Age_____ Color_____ DOB/Age_____
Is this horse insured? YES _____NO_____ Is this horse insured? YES _____NO_____

Name_____ Name_____
Reg. Name_____ Reg. Name_____
Breed_____ Breed_____
Sex_____ Sex_____
Color_____ DOB/Age_____ Color_____ DOB/Age_____
Is this horse insured? YES _____NO_____ Is this horse insured? YES _____NO_____

Appointment Cancelation Policy

If you miss an appointment or fail to cancel without 24 hours advanced notice of your appointment time, a $90 fee will be applied to your account. _____ (Initial)

Authorizing Treatment.

I hereby authorize the doctors at High Water Veterinary Services to perform veterinary services on my horse(s). Should unexpected life-saving emergency care be required, and my attending veterinarian is unable to reach me or my agent, I hereby give my permission to provide such treatment and I agree to pay for such care. I understand that I am encouraged to discuss all fees related to such care before services are rendered and during my animal's ongoing medical treatment.

I understand that payment is due when services are rendered, unless a credit card is on file with the office. I understand that credit will only be extended with the submission of a credit card number, which I agree will be charged if payment in full is not received by High Water Veterinary Services within 30 days of service being given. In the event of an overdue balance, I agree to pay a monthly billing and financing fee equal to 2% of the unpaid balance or $5.00, whichever is greater. If legal action is necessary to collect unpaid invoices, I agree that all costs of collection will be charged to me. I understand that my first visit must be paid for at the time of service.

Signature: _____ Date: _____

An adult over 18 years of age must sign this form as the person financially responsible for the patient.

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Credit Card Authorization

MasterCard Visa Discover Amex Care Credit

(Circle one)

Expiration Date:_____ Verification Code (3-4 digit code) _____

Name On Card: _____

Is billing address same as your home address? ____Yes____No *(If no please provide billing address)*

Billing Address:

_____

_____

☐ Please automatically charge my credit card for all charges incurred for each invoice.

☐ Please send my statement by EMAIL. I authorize you to charge my credit card if you have not received my payment by check by the 25th of the month the statement was generated.

☐ For payment at my first visit, I would like to use:

☐ Credit Card ☐ Check ☐ Cash ☐ PayPal ☐ Care Credit

I understand that credit will only be extended by High Water Veterinary Services with the submission of a credit card number, which I agree will be charged if payment in full by check or cash is not received by High Water Veterinary Services within 30 days of service being given.

Signature: _____ Date: _____

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As many clients utilize farm managers, trainers and others to request veterinary services or supplies for the care or treatment of your horses, it is important that we have your written permission on file to provide veterinary care requested by third parties. In addition, in an emergency, we may be unable to reach you, and need to understand your wishes. In an effort to prevent misunderstandings or confusion, and prevent billing errors, please clarify who has permission to act on your behalf. Please complete the form below and return it to our office in a timely manner.

Client Name: _____ E-Mail: _____

Home Phone: _____ Cell phone: _____

Name(s) and location of Horse(s):

Name of horse	***Location of horse (e.g. home, boarding barn name)***

Are any individuals permitted to call in for appointments and request/authorize non-emergency care:
Yes___ No___

Are any individuals permitted to call in for appointments and request/authorize emergency care:
Yes____No
____

Is a "Good Samaritan" authorized to seek emergency service in the event of a severe or life-threatening situation?
Yes_____ No_____

If Yes, list below, and check appropriate boxes

Name of Agent	***Phone number***	***Non-Emergency Authorization***	***Emergency Authorization***

Would you like to place a financial limit on emergency care we may perform until we are able to contact you? Yes ____
No_____
If Yes, please specify amount (minimum $750.00) _____

Can your listed agent(s) authorize the following care, **<u>if we are unable to reach you</u>**?
Surgical Referral (Requires $1000 deposit) Yes ___ No_____
Admission to hospital (Requires $1000 deposit) Yes _____ No_____
Emergency Euthanasia (In case of obvious fractures/ severe colic / significant pain) Yes____ No_____

Limitations requested per individual horse. Please describe limitations: (e.g. "For elderly horse Blaze, authorize treatment only on farm, with financial limit of $750.00. For young horse Star, emergency care including referral and surgery authorized, with financial limit of $7500.00)

_____
_____
_____
_____
_____
_____
_____

By granting such permission you agree that you will be financially responsible for veterinary services and supplies provided at the request of the individuals listed above, or those performed in an emergency at the recommendation of the veterinarian.

Signature_____ Date: _____

e-mail to: Highwatervet@gmail.com