INSTITUTE *of*
VETERINARY SPECIALISTS

OFFICE USE:

ENROLLMENT AND TERMS AGREEMENT

(PLEASE PRINT)

Clinic name: _____

Legal business name (If Different): _____

Shipping Address

Street: _____

City: _____

State: _____ **Zip:** _____

Local Major City: _____

Billing Address (❑ Check if same as shipping)

Street: _____

City: _____

State: _____ ***Zip:*** _____

Telephone/Fax Numbers

Phone: _____ **Fax:** _____

Other (Specify): _____

How would you like your reports/statements delivered:

Preop/Screening: Verbal results with:

❑ e-mailed report ❑ faxed report ❑ no written report

❑ both e-mailed and faxed

Full Reports (Phone/STAT/Code Red): Verbal results with:

❑ e-mailed report ❑ faxed report ❑ both e-mailed and faxed

Statements:

❑ e-mailed ❑ sent via USPS

Clinic e-mail: _____

Manager/Acct Contact name: _____

Doctor Name(s): _____

Owner/Principal's Name: _____ **Social Sec #: *** _____-_____-_____

Home Address: _____

City: _____ **State:** _____ **Zip code:** _____ **Home Phone:** _____

How did you hear about us? _____

Billing Options (choose one):

❑ **I prefer to be billed monthly** * (Social Security Number Required for Credit Purposes)

❑ **I prefer to have my credit card automatically debited monthly** (Please fill out below.)

❑ Visa ❑ MC ❑ Disc **Card Number:** _____ **Exp. Date:** _____

3-digit verification code: _____ **Name On Account:** _____

Billing Address **of Credit Card:** _____

Cardholder Signature: _____

Do you own an ECG Transmitter? ❑ **Yes (Clips: 2 or 4)** ❑ **No (❑ I am interested in purchasing one)**

Terms are payable upon receipt. Finance charges of 1.5% per month (18% Annual) will be assessed on any balance unpaid after 30 days. Past due accounts are subject to credit restrictions and credit holds. Payment may be made by business check, Visa, MasterCard and Discover. There is a returned check fee of $25.00. By signing this agreement, I personally consent to pay any outstanding debt, including collection and/or any reasonable legal fees. I have provided the correct information above and I agree to the terms and conditions contained herein.

Owner/Principal Signature: _____ **Date:** _____

Please e-mail or fax this form to: **Institute of Veterinary Specialists**
contact@vetheart.com **Phone: 1-888-844-1019** **Fax: 1-888-844-1413**