



**INSTITUTE *of*
VETERINARY SPECIALISTS**

OFFICE USE:

ENROLLMENT AND TERMS AGREEMENT
(PLEASE PRINT)

Clinic name: _____

Legal business name (If Different): _____

<p>Shipping Address</p> <p>Street: _____</p> <p>City: _____</p> <p>State: _____ Zip: _____</p> <p>Local Major City: _____</p>	<p>How would you like your reports/statements delivered:</p> <p>Preop/Screening: Verbal results with:</p> <p><input type="checkbox"/> e-mailed report <input type="checkbox"/> faxed report <input type="checkbox"/> no written report</p> <p><input type="checkbox"/> both e-mailed and faxed</p> <p>Full Reports (Phone/STAT/Code Red): Verbal results with:</p> <p><input type="checkbox"/> e-mailed report <input type="checkbox"/> faxed report <input type="checkbox"/> both e-mailed and faxed</p> <p>Statements:</p> <p><input type="checkbox"/> e-mailed <input type="checkbox"/> sent via USPS</p> <p>Clinic e-mail: _____</p>
<p>Billing Address (<input type="checkbox"/> Check if same as shipping)</p> <p>Street: _____</p> <p>City: _____</p> <p>State: _____ Zip: _____</p>	
<p>Telephone/Fax Numbers</p> <p>Phone: _____ Fax: _____</p> <p>Other (Specify): _____</p>	

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 (Please describe: _____) 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