Caroline Veterinary Clinic
9 N. Central Ave.
Ridgely, MD 21660
410-634-2666

ADULT CANINE PREVENTATIVE HEALTHCARE PACKAGE

Client ______________________ Dog's name _______________________
Address_____________________ Additional dogs: ____________________
_____________________ ______________________
Phone _____________________ ______________________

Thank you for choosing to protect the health of your dog with our Adult Canine Preventative Healthcare Package. This package is designed to help you provide the best preventative healthcare for your dog. Monthly payments will be made automatically from your checking account.

Included in this plan, for **$20 per month (per dog)**, are the following services:

Two wellness visits per year (every six months)
All vaccines your dog requires based on his or her individual risks.
These vaccines include Rabies, DHPP, Leptospirosis, Lyme Disease, and Kennel Cough. Note: Not all dogs need all of these vaccines every year.
NOTE: If a 3 week booster vaccine is needed for any of the above vaccines, a charge will apply for the booster.
Annual Heartworm test and Tick Screen
Annual Intestinal Parasite Screen

15% discount on heartworm and flea/tick products
10% discount on all other medications and services (except food)
If an item or service is on special, the discount will be the special or the above discount, whichever is more.

For **$25 per month (per dog)**, we offer *all of the above* plus an annual wellness blood screen
Including CBC (complete blood count) and comprehensive chemistry profile.

NOTE: This plan includes only wellness visits and not visits when your pet is sick or injured (except for the described discount). Also, if your pet requires additional diagnostics or treatments during a wellness visit, payment for those services will be due at the time they are rendered. __________ (initial)

There is a $20 one time registration fee to be paid with the first month's payment. Additional pets can be registered at the same time for $10. Discounts begin at the time of registration. Wellness visits and vaccinations can begin after four payments have been made. ___________ (initial)

If you need to cancel this package for any reason, you will be responsible for the services that have been provided, at regular prices. We will provide a written statement of the services used during the current year of the plan and the amount that is due. If your account has a balance due, the regular monthly payment will be charged as normal until the balance has been satisfied unless you elect to pay otherwise. No refunds will be made under any circumstances. ________(initial)

If the Caroline Veterinary Clinic is unable to process your payment, you will be responsible for an alternate payment method along with a $5 late fee plus 1.5% interest per month. If this occurs three times, your plan will be cancelled. Any account that is not paid in full for 90 days will be sent to collections. _______(initial)

By signing this authorization, I acknowledge that I have read and agree to all of the above.

_____________________________ (signature)

_____________________________ (print name)

____________ (Date)

DIRECT PAYMENT VIA ACH (ACH DEBIT)

CONSUMER AUTHORIZATION FOR DIRECT PAYMENT VIA ACH (ACH DEBITS)

Direct Payment via ACH is the transfer of funds from a consumer account for the purpose of making a payment.

I (we) authorize **Caroline Veterinary Clinic** ("COMPANY") to electronically debit my (our) account (and, if necessary, electronically credit my (our) account to correct erroneous debits[1]) as follows:

☐ Checking Account / ☐ Savings Account (select one) at the depository financial institution named below ("DEPOSITORY"). I (we) agree that ACH transactions I (we) authorize comply with all applicable law.

If you have chosen "Checking Account" above, please provide a voided check.

Depository Name______________________________

Routing Number________________ Account Number________________________________

Amount of debit(s) or method of determining amount of debit(s) (specify the plan you have chosen and dollar amounts authorized) ____.

Date(s) and/or frequency of debit(s): Once a month on the 5th of the month or next business day.

I (we) understand that this authorization will remain in full force and effect until I (we) notify Company in writing to 9 N. Central Avenue, Ridgely MD 21660 that I (we) wish to revoke this authorization. I (we) understand that Company requires 10 days notice and for our account to be paid in full for services already rendered in order to cancel this authorization.

Name(s)____
(Please Print)

Date_________ Signature(s)____

[1]The *NACHA Operating Rules* do not require the consumer's express authorization to initiate Reversing Entries to correct erroneous transactions. However, Originators should consider obtaining express authorization of debits or credits to correct errors.

[2]Written debit authorizations must provide that the Receiver may revoke the authorization only by notifying the Originator in the time and manner stated in the authorization. The reference to notification should be filled with a statement of the time and manner that notification must be given in order to provide company a reasonable opportunity to act on it (e.g., "In writing by mail to 100 Main Street, Anytown, NY that is received at least three (3) days prior to the proposed effective date of the termination of authorization").

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