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**2010 Wellness Program Agreement**

Adult Horse	Show Horse	Geriatric Horse	Foal
\$312 - \$332	\$382 - \$422	\$432 - \$452	\$294 - \$324

Upon return of this agreement with your horse's information, your information (including your signature) and payment for the appropriate amount, your horse will be entered into the **2010 Riverbend Equine Medical Center Wellness Program**. You will be contacted by Riverbend Equine Medical Center for appointment scheduling.

By signing this form, you agree to the terms laid out in the Wellness Programs, and understand what services are included and which are not.

- \*The wellness plan runs for the 2010 calendar year. All services must be used by December 31, 2010.
- \*This plan is **NOT** refundable should you sell your horse.
- \*This plan is **NOT** transferable between owners.

**Fill out the back of this page with horse information and selected plans.**

Owner Name \_\_\_\_\_

Address \_\_\_\_\_

Phone number \_\_\_\_\_ Other phone number \_\_\_\_\_

Method of Payment: ( ) Cash ( ) Check ( ) Credit Card - VISA, Master Card, and Discover

Card Number: \_\_\_\_\_ Exp. Date \_\_\_\_\_

Sec. Code (3 digit) \_\_\_\_\_

Name and billing address of Credit Card (If different from above)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Owner Signature \_\_\_\_\_ Date \_\_\_\_\_

Name of Horse: \_\_\_\_\_

Breed: \_\_\_\_\_ Sex: \_\_\_\_\_ DOB: \_\_\_\_\_

Color/Markings: \_\_\_\_\_

Selected Wellness Plan: \_\_\_\_\_  
Previous Medical History: \_\_\_\_\_

Name of Horse: \_\_\_\_\_

Breed: \_\_\_\_\_ Sex: \_\_\_\_\_ DOB: \_\_\_\_\_

Color/Markings: \_\_\_\_\_

Selected Wellness Plan: \_\_\_\_\_  
Previous Medical History: \_\_\_\_\_

Name of Horse: \_\_\_\_\_

Breed: \_\_\_\_\_ Sex: \_\_\_\_\_ DOB: \_\_\_\_\_

Color/Markings: \_\_\_\_\_

Selected Wellness Plan: \_\_\_\_\_  
Previous Medical History: \_\_\_\_\_

Name of Horse: \_\_\_\_\_

Breed: \_\_\_\_\_ Sex: \_\_\_\_\_ DOB: \_\_\_\_\_

Color/Markings: \_\_\_\_\_

Selected Wellness Plan: \_\_\_\_\_  
Previous Medical History: \_\_\_\_\_

Name of Horse: \_\_\_\_\_

Breed: \_\_\_\_\_ Sex: \_\_\_\_\_ DOB: \_\_\_\_\_

Color/Markings: \_\_\_\_\_

Selected Wellness Plan: \_\_\_\_\_  
Previous Medical History: \_\_\_\_\_