

CLIENT INFORMATION

We require that all pets admitted to our hospital be current on vaccinations.

Date: _____
Referred By: _____

Hours of Operation
Monday - Friday: 7:30am – 6:00pm
Saturday: 8:00am – 12:00pm
Sunday: Closed

Owner's Name: _____

First Middle Last

Street Address: _____
Apt #: _____
City: _____
State: _____
Zip: _____
 Own
 Rent

All professional fees are due at the time services are rendered.

We will gladly prepare a written estimate is requested. We accept Master Card, Visa, Discover, American Express, Care Credit, cash and personal checks.

Home Address (if different from above)
Street Address: _____
Apt #: _____
City: _____
State: _____
Zip: _____

I understand that payment in full is due from the date of purchases on my account; however I agree to pay a FINANCE CHARGE of 1.5% per month on balances over thirty (30) days past due, which is an ANNUAL PERCENTAGE RATE OF 18%. Any balance over 60 days will incur a \$5.00 billing fee. If my account is referred to an attorney for collection, upon said referral I agree to pay attorney's fee in the amount of thirty-three and one third percent (33 1/3%) of the total outstanding indebtedness (which includes, but not limited to, principal, accrued interest and late charges) then due and all costs of collection. I agree to pay aforesaid attorney's fees and costs of collection whether or not attorney files suit.

Home Phone: _____
Cell Phone: _____
Work Phone: _____
Email Address: _____

Owner's Employer: _____
Work Address: _____
Work Phone: _____

Signature Owner: _____
Date: _____

Spouse/Co-Owner: _____

First Middle Last

Signature Co-Owner: _____
Date: _____

Co-Owner Phone: _____
Cell Phone: _____
Work Phone: _____
Co-Owner's Employer: _____

Identification Verified (for office use only)

Thank you!

