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Thank you for giving our hospital the opportunity to care for your pe(s)!. So that we may be better able to meet your needs, please complete the following.

New Client Information

Name _____ Spouse Name _____

Address _____

City _____

State _____

Zip _____

Phone Numbers:

Home _____

Cell _____

Work _____

Spouse Cell _____

Spouse Work _____

Employment _____

Spouse's Employment _____

E-mail address(es) _____

(We use your e-mail address to send patient medical notes, updates and our quarterly newsletter if you opt to receive it.)

How did you become aware of our hospital? _____

If you were referred, please note the name of the person that referred you: _____

Terms of Service

PAYMENT IN FULL is required at the time services are rendered. We do not offer any form of billing.

We accept cash, VISA, Mastercard, American Express and Care Credit as forms of payment. We no longer accept checks. Advanced minimum deposit of half of your estimate is expected from you for all after-hour calls and for animals left in the clinic for overnight treatment or diagnostics. This also applies to extensive treatment of severely ill patients or boarders staying longer than one week unless prior arrangements have been made.

All information I have provided here is true to the best of my knowledge. **I have read and understand the Terms of Service.**

Signature _____ Date _____