

COMPASSION • HOPE • EXPERIENCE



VSNT

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OWNER'S INFORMATION:

Owner's Name: _____
Spouse/Partner: _____
Street Address: _____
City, State, Zip: _____
Owner's Phone: _____
Preferred method of contact: Phone _____
 Text _____
 Email _____

PATIENT INFORMATION:

Patient's Name: _____
Type: Dog Cat DOB or age: _____
Breed: _____ Color: _____
Sex: Male Female
 Male Neutered Female Spayed
Referring Doctor: _____
Hospital Name: _____
Reason for referral: _____
Primary doctor: _____
(if different than above)

PAYMENT POLICY:

Please select your choice of payment:

- Credit Card
 Cash
 Check

Payment in full is due when services are rendered. A deposit may be required before extensive testing may be done. A detailed estimate will be provided prior to any procedures. In order to avoid future misunderstandings, please thoroughly discuss your pet's treatment plan and fees with the doctor prior to approving any services.

A \$25 fee will be added to all returned checks. Any unpaid balances carried to the following month will accrue an interest rate of 2% per month compounded. Statements will be sent at the end of each month and past due accounts will subsequently be turned over to a collection agency for collection of all unpaid balance, plus interest, and collection fees.

Images of your pet may be used for educational or marketing purposes. YES NO

SIGNATURE OF OWNER/RESPONSIBLE PARTY:

(must be at least 18 years of age) Date _____