NEW CLIENT INFORMATION

WELCOME TO BEST FRIENDS ANIMAL HOSPITAL

OWNER'S NAME (❑MR. ❑MRS. ❑MS.)_____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE: HOME _____ CELL _____ WORK _____

FAX: HOME _____ WORK _____

EMAIL _____

EMPLOYER _____ ADDRESS _____

SPOUSE _____ EMPLOYER _____

YOUR PET'S INFORMATION

NAME	SPECIES	BREED	COLOR	BIRTHDAY	SEX	NEUTERED?
	CANINE OR FELINE					**Y** OR **N**
	CANINE OR FELINE					**Y** OR **N**
	CANINE OR FELINE					**Y** OR **N**

DATE OF LAST EXAM: _____ YOUR PET'S MICROCHIP NUMBER _____

USUAL DIET (BRAND NAME) _____

DOES YOUR PET HAVE ANY KNOWN ALLERGIES? _____

HOW DID YOU FIND US? ❑ YELLOW PAGES ❑ PET PAGES ❑ INTERNET ❑ DRIVE/WALK BY ❑ OTHER _____

❑ REFERRED BY FAMILY/FRIEND (THEIR NAME SO WE MAY THANK THEM_____)

HOSPITAL TREATMENT POLICY

IF YOU HAVE ANY QUESTIONS, PLEASE DO NOT HESITATE TO ASK. WE ARE HERE TO HELP YOU GET THE VETERINARY CARE YOU WANT OR NEED.

- IN ADMITTING MY PET(S) FOR DIAGNOSTICS, TREATMENT, OR SURGERY, I AUTHORIZE THE VETERINARIANS OF BEST FRIENDS ANIMAL HOSPITAL, AND THEIR SUPPORT STAFF, TO ADMINISTER SUCH TREATMENT AND/OR PERFORM SUCH DIAGNOSTIC OR SURGICAL PROCEDURES AS DEEMED NECESSARY.
- IT IS UNDERSTOOD THAT A TREATMENT PLAN OF CHARGES CAN BE GIVEN FOR SERVICES. NO GUARANTEE OR ASSURANCES CAN BE MADE AS TO THE RESULTS THAT MAY BE OBTAINED.
- FURTHER, I UNDERSTAND THAT A DEPOSIT OF 50% MAY BE REQUIRED BEFORE SERVICES ARE PERFORMED AND I ASSUME FULL FINANCIAL RESPONSIBILITY FOR ALL CHARGES INCURRED BY MY PET. I REALIZE THAT THESE CHARGES MAY EXCEED A GIVEN TREATMENT PLAN ESTIMATE IF COMPLICATIONS ARISE. I UNDERSTAND THAT I WILL BE CONTACTED PRIOR TO TREATMENT, IF POSSIBLE, SHOULD COMPLICATIONS OCCUR.

_____

SIGNATURE OF PET OWNER **DATE**

PAYMENT IS EXPECTED IN FULL ON DAY SERVICES ARE RENDERED.
THANK YOU.

WRITTEN FINANCIAL POLICY

PAYMENTS

- We accept Visa, Mastercard, Discover, Carecredit, Cash, Personal Check. We do not accpet American Express at this time.
- Your personal check is welcome. We use the telecheck system. By presenting your check you authorize, if the check is returned unpaid, collection of check, return fee and costs by electronic funds transfer or draft drawn from your account.
- I agree that should my account become delinquent, I will be responsible for all collection costs, including but not limited to the outstanding balance, attorney fees, court costs, collection agency fees and interest at the rate of 18% per annum (1.5% per month)

MISSED APPOINTMENTS

- This clinic provides care for many clients and their pets and missed visits result in time lost that could have been used to provide veterinary care to other sick pets. It is our policy to assess a $30 missed appointment fee to clients who do not show or cancel appointments with less than a 24-hour notice. One missed visit will not result in the assessment of a fee, but you will be charged for any additional missed visits.

My signature below indicates I understand the above financial policy.

SIGNATURE OF PET OWNER **DATE**