



--

Please print clearly and make sure that the information given is specific to the client name listed here. Thank you.

Email-address _____

Have you been to our facility before? ☐ Yes ☐ No

Has this pet been seen at our facility before? ☐ Yes ☐ No

Doctor _____ Clinic Name _____

👉 All medical fees must be paid in full at the time of service 👉

Additional fees may apply for emergency consults with board certified specialists. **Please note; fees for diagnostic procedures and treatment are not included in the exam/consult fee.** Your doctor will discuss diagnostic and treatment options during your initial consult.

We accept the following forms of payment. Please indicate how you will pay for services today:

☐ Cash ☐ Check (valid driver's license required) ☐ Credit/Debit Card (Mastercard/Visa/Discover/AMEX) ☐ Care Credit

Your signature verifies that you are the owner or authorized agent for the owner of the pet listed above, that you are at least 18 years of age, and that you are the individual responsible for payment of all medical fees.

Client's Signature X

Date _____