



NEW CLIENT FORM

Client Info

Owner: _____ Home phone _____

Co-Owner/Spouse _____ Work phone _____

Cell phone _____

Address _____

City _____ State _____ Zip _____

Email: _____ Driver's License _____

Would you like to receive reminders and informational notices via email? YES NO

Employer: _____

Employer Address: _____

Whom can we thank for your business? _____

(Sign, Drove by, Personal Referral-please include individual's name)

Pet Info

1. Name: _____ Dog Cat Bird Other _____

Breed: _____ Color: _____

Female

Female Spayed

Male

Male Neutered

Birth Date or Age: _____ Age pet obtained _____

Pet obtained from Shelter Friend Breeder Rescue group _____

Previous vet where past records can be obtained _____

2. Name: _____ Dog Cat Bird Other _____

Breed: _____ Color: _____

Female

Female Spayed

Male

Male Neutered

Birth Date or Age: _____ Age pet obtained _____

Pet obtained from Shelter Friend Breeder Rescue group _____

Previous vet where past records can be obtained _____

EXAMINATION & TREATMENT AUTHORIZATION and ASSUMPTION OF FINANCIAL RESPONSIBILITY

To maintain our high quality of care, Hartwood Animal Hospital is dependant upon payment of services at the time they are rendered. For this reason the hospital does not extend credit (bill). We accept cash, check (w/ID), VISA, & Mastercard. We will be glad to provide a treatment plan for services at any time. A deposit will be required prior to starting treatment for surgical and hospitalized patients.

I, the undersigned, authorize the Doctors and staff of Hartwood Animal Hospital to examine and treat the above described pet(s) and to administer any medical, surgical treatments and/or tests, including sedation or anesthesia which is considered necessary based on findings during the course of examinations. I understand that any treatments performed will be with my full knowledge and consent except in emergency situations.

I assume responsibility for all charges incurred for services rendered to the patient. I understand there is a \$30.00 service charge for returned checks and that after thirty (30) days unpaid accounts may accrue interest at the rate of 1.5% per month (18% per annum) monthly. If collection action is necessary on this account, I agree to pay all costs of collection of 33% of the balance owed plus attorney fees, whether or not the suit is filed. The parties agree to the exclusive venue and jurisdiction of Stafford County, Virginia, for all matters arising from this agreement.

Signature _____ Date _____