Client ID ___________

Client Information

CLIENT NAME: ____
First Middle Last

ADDRESS: ____
____
Zip Code City State

PHONE NUMBER(S): (__)____-_______ (__)____-_______
Home Work/Cell

DOB: _______ DRIVERS LICENSE#: ____________ EMPLOYER:__________________

REFERRED BY: ________________E-MAIL___________________________

Patient Information

PATIENT NAME: ____________________________________
SPECIES: _______________________ BREED: __________________
AGE/DATE OF BIRTH: ____________ GENDER: _________________
COLOR: ________________________ SPAYED/NEUTERED: ________
MICROCHIP OR TATTOO # ____________________________________

Office Policies

PAYMENT:

- It is our policy to require full payment of all office charges at the time they are received, unless prior arrangements have specifically been made with those in authority to do so.
-I understand that in the event of default of the above policies, I agree to pay all collection costs, but not limited to, reasonable attorney fees, court costs, cost of preparing documents for courts and collection agency fees up to 50% of unpaid balance, whether incurred by filing a lawsuit or otherwise.
-I agree to pay interest on the account of 1.5% per month (18% annum). If it becomes necessary to refer the account to a collection agency, I agree to pay a collection fee of 35% of the principal balance owing. Further, I agree to pay for any and all attorney fees should legal action become necessary.
-Should collection become necessary, I hereby expressly agree to pay all costs of collection including an additional fee up to 50% whether of not the account is turned to an outside collection agency. I further agree to pay all court costs and attorney fees should legal action become necessary.

AUTHORIZED FOR RELEASE OF MEDICAL RECORDS:

I authorize the doctor to release any medical information including diagnosis, x-rays, test results, reports and records pertaining to any treatment or examination rendered to my pet. I understand that this medical information may be used for any of the following purposes: diagnostic, legal, and at times when the doctor deems necessary to ensure the best medical care possible on my pet's behalf.

AGREEMENT OF TERMS AND PERMISSION TO TREAT:

I have read the above, and agree to the terms and conditions therein. To my knowledge, the information contained in this document is accurate as of the day this form is signed. I give permission for the veterinarian(s) of RiverWoods Pet Hospital, paraprofessional staff, and any other professional necessary to treat my pet, authorization to do so. I understand no guarantee as to results or cure can be made by this establishment. If I neglect to pick up my pet by the agreed upon date/time, I am liable for boarding charges. If my pet is left for three or more days without prior agreement and no contact by responsible party has been made, the pet is considered to be abandoned, and will become property of RiverWoods Pet Hospital.

_______________________________________ ________________
Client Signature Date