Buffalo Small Animal Hospital

WELCOME to our practice! For the comfort and safety of people and their pets, Dogs must be well-controlled on a leash, and Cats must be in a carrier. Thank you for your consideration!

CLIENT (Your) INFORMATION:

Name:_____ **Birth date:** ___/___/_____

Co-Owner Name_____**Relationship:**_____**Birth date:**___/___/_____

Primary Phone:_____ **Alternate Phone:**_____

Address: _____ **E-mail:**_____

City: _____ **State:** _____ **Zip**_____ **Driver's License #:** _____-____-_____

How did you hear about our practice? _____
Pet Pals Referral- Whom should we thank for referring you to our practice? _____

PET INFORMATION:

Pet's Name: _____ **Dog / Cat** **Age**_____ **Breed:** _____

Gender Male/ Female **Neutered**: Yes / No **Color**_____ **Markings**:_____

Microchipped? Chip #_____

Please indicate any current medical problems your pet may have:

_____

Do you have additional health records to provide? See attached. Previous Veterinarian_____

Are you interested in information about our Pet Annual Wellness Plans (PAW Plan)? Yes/No

Missed appointment policy: We understand life can happen and do allow for a missed appointment. However after missing more than one appointment with less than a day's notice of cancellation, we will require you to leave a deposit to book future appointments. When we are provided with notice, another sick patient can likely be cared for during that time.

To prevent the spread of infectious diseases and parasites in our hospital, all boarding and hospitalized pets must be kept current on vaccines and free of internal and external parasites. I hereby authorize the performance of accepted diagnostic, therapeutic, and/or surgical procedures. I accept financial responsibility for these services Unfortunately we are unable to offer billing or payment plans. *Upon request we will gladly prepare a written treatment plan for any services recommended to be performed.
PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED. (See Payment Policy)

I am the owner of the above animal or have authority to consent to its treatment.

_____ Date _____/_____/_____
Signature (Owner or Agent)

_____ Date _____/_____/_____
Signature (CO-Owner or Agent)

Buffalo Small Animal Hospital

Payment is due at the time services are provided

Please understand that in order to provide optimal care and staffing, we are unable to bill or accept payment plans for services rendered. At any time you may ask for a treatment plan or an explanation of costs.

We accept Cash, Visa, MasterCard, Discover, Amex and Care Credit.

We will also accept personal checks (returned check fee for insufficient funds = $45) with the following information: Date of birth:____/____/_____ SS#_____-____-_____

Checks should be made payable to: Buffalo Small Animal Hospital.

In the event that a client has an outstanding balance, we will send statement(s) requesting payment. A $4 Statement fee will be added to the balance as a processing/late fee. Late fees are non-refundable and will continue to accrue until balance is paid in full.

If an account goes into default, I understand it will be placed with a collections agency and you agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 33 1/3% of the debt, and all costs and expenses, including reasonable attorney's fees we may incur in such collection efforts. Our collections agency is Security Credit Systems Inc. 622 Main Street Suite 301 Buffalo, NY 14202. Once in default, Buffalo Small Animal Hospital will take all necessary means to collect the amount owed and you will forfeit future services by our hospital.

I understand and agree that if I default on my balance owed, Buffalo Small Animal Hospital may disclose the fact that I have defaulted and other relevant information to the credit bureau organizations.

Print Name_____ Phone #_____

Signature_____ Date_____

Patient Release Of Medical Records Authorization

Buffalo Small Animal Hospital

243 South Elmwood Ave Buffalo, NY 14201

Please forward a copy of my pet's records to:

Fax: 716-853-0137 Phone: 716-852-1112
Email: Buffalosmallanimal@nva.com

Pet Name(s): _____ _____
Breed: _____ Sex: M / F Age: _____

I am the owner or authorized agent for the above mentioned pet(s) and request and give my permission to release medical records in their entirety including any images or lab-work for my above named pet(s) to Buffalo Small Animal Hospital.

_____ Date _____/_____/____
Signature (Owner or Agent)

_____ Phone# (_____)_____-____
Print Name

Buffalo Small Animal Hospital

Photo/Testimonial Release Form

We love posting cuteness and educational opportunities! With your consent, we would like to be able to post your pet's photo and maybe a story on Facebook or on our website at www.buffalovet.com

Owner's name_____

Email Address_____

Pet name_____DOB_____Breed_____

I give Buffalo Small Animal Hospital permission to use my testimonial (or photo) provided for reproduction in any medium including but not limited to: website, video, broadcast, print, and electronic means for purposes of advertising, trade, display, exhibition, or editorial use. Further, I also agree to release Buffalo Small Animal Hospital from all claims for libel, slander, invasion of privacy, infringement of copyright or right of publicity or any other claim and I confirm that I am over 18 years of age.

Owner personal information will not be included unless consent is given by the owner.

I consent to use of my information:_____Initials.

Signature_____***Date***_____

Comments / Testimonial:

_____