



Client Information



We are pleased to welcome you and your pets to our practice. If you have any questions we will be glad to help you. We look forward to working with you in maintaining your pet's health.

PLEASE FILL OUT THE FORM COMPLETELY

Are you new to our clinic? Yes No

Primary Owner Contact _____ Phone _____ Cell

Secondary Owner _____ Phone _____ Cell

Mailing Address _____

Physical Address _____ Apt# _____

City _____ State _____ Zip _____

Primary Contact number where you want to receive text reminders for your pet(s): (Cell Phone _____)

May we send you reminders for your pets and other important medical information by email? Yes ___ No ___

Email address for Pet Portal and Pet Reminders: _____ @ _____

Work Phone _____ Ext# _____ Alt Phone# _____

BESIDES YOU, In case of an emergency who should we contact? Name: _____

Phone#: _____ Cell Relationship: _____

How did you learn of our clinic? Yellow Pages Sign Website Google AAHA Other _____ Recommendation

If recommended, by whom? _____

Please update us on your current pet(s) in the household (provide their names): _____

AUTHORIZATION

I am at least 18 years of age and I hereby authorize the veterinarian(s)/employees of Hanford Veterinary Hospital to examine, receive, prescribe for, treat or perform surgical services upon my pet(s). I assume all responsibility for all charges incurred in the care of my pets. I also understand that the fees will be paid at the time services are rendered and that a 75% deposit is required prior to any treatment. I agree to pay for reasonable costs of collection, attorney fees, and court costs in the event that collection efforts become necessary. I understand that a billing charge of \$5.00 per month and 1.5% per month (18%APR), will be charged on all unpaid balances after 30 days. I fully understand that you do not offer payment plans or revolving credit accounts.

I understand that veterinary service during nighttime hours, some daytime hours, and/or weekends, is provided at the discretion of the veterinarian in charge. Continuous presence of personnel may not be provided during these hours. I understand that if my pet is not picked up after 10 days my pet will be considered abandoned and may be disposed of, or destroyed, as you deem best, and it is understood that your doing so does not relieve me from financial responsibility including the cost of treatment and keep.

I understand the following hospital policies: **Leashes & Carriers** - We require that your dogs are on leashes and your cats are in carriers when you visit our clinic. We are located next to a busy street and we would not want any of your pets escaping. Please be sure to have your children ask permission to touch other client's pets, not all animals are friendly with strangers. **Appointment Cancellations** - We strongly uphold a 24-hour cancellation policy and ask that you adhere to this policy. If an appointment is missed or not cancelled before the 24-hour cancellation time frame, there will be a missed appointment fee.

I grant Hanford Veterinary Hospital permission to post my pet's picture, story and medical information on social media. I decline _____ all social media (initial).

Signature of Owner (Representative) _____ Date _____

Method of Payments Accepted:

Cash, Debit, Visa, MasterCard, AMEX, Discover, Check (electronic debit through Cross Checks & DL# required), or Care Credit

Office Use: Client ID# _____ Team Member Initials: _____