Parkview Animal Hospital 1972 11 Mile Road, Warren, MI 48091 Phone: (586) 573-4760

## **STANDARD CONSENT & CLIENT INFORMATION FORM**

(Last)	(First)
Zip:	Primary Phone:
<mark>-</mark>	Secondary Phone:
*	Work Phone:
	Spouse Phone
	to dispense controlled medications.  TO RECEPTIONIST SO WE CAN MAKE
	OUR RECORDS
ANIMAL	INFORMATION
Species:	Breed:
Sex: M/F Spayed/Net	utered? Birthdate:
nd Date:	
ho have been patients with	us before? If yes, what names?
become aware o	of our clinic?
_	nternet Other
	Spouse's name:  Spouse's name:  Required by law in order to the copy for the copy f

## Please give any paperwork from previous vets to the receptionist so we can make copies.

I certify that I am the owner of the above pet, *and I am 18 years of age or older*, or I am acting as an agent for the owner, and accept full financial responsibility. Payment is due as services are rendered. For patients requiring hospitalization, a deposit of 50% of the estimated cost is required in advance. The balance is due at the time the patient is discharged from the hospital. Payment may be in the form of cash, check (with proper identification) Visa, MasterCard, AMEX, Discover, or Care Credit. In order to avoid misunderstandings, please let us know if these terms are unsatisfactory. The pet owner (or responsible agent) is financially responsible to Parkview Animal Hospital for all applicable charges as pertaining to the pet's care.

"I, the undersigned, have read and agree to the above financial policy and I understand my financial obligation."

C:	Daka	
Signature:	Date:	
0.0	 _ 0.00.	

If the email process does not automatically start after you click the submit button, please send forms to Parkview1972@gmail.com