Community Animal Hospital

Client Information Form

Rev: 7/15/20

The persons listed below must be legally allowed to make medical decisions for their pets and are considered financially responsible.

Owner's Name:_____ *Date of Birth:_____

Spouse's Name:_____ *Driver's License:_____

Mailing Address:_____ Employers Name:_____Street Address:_____ Work Number: _____

City, State, Zip:_____ In the event that we cannot reach you, Please provide

Home Phone Number:_____ an emergency contact - Relation: _____

Cell Phone Number: _____ Name: _____

E-mail address: _____ Phone Number: _____

We now offer 24-hour access to pet medical records, scheduling, and medication refill requests through PetDesk. Download the app today for Apple or Android phones.

Do you consent to allow Community Animal Hospital to use images of your pets on social media? _____

General Pet Information:

Please list the number and types of pets in your home:

_____

_____

If you have been referred for care by another hospital:

Name of referring hospital: _____ Doctor: _____

Would you like records sent back to this hospital? _____

Do you wish to receive reminders from Community Animal Hospital? _____

How Did You Become Aware of our Hospital?

Hospital Sign □ Yellow Pages □ Internet □ an Individual, who? _____

Discount Policy

Community Animal Hospital offers discounts for several communities including Military Personal, First Responders, and Seniors (*Wednesday only*). Discounts are offered to regular clients on services only, excluding grooming and boarding. Discounts are offered for each visit up to a maximum of 10% or $100.00. Identification is required to establish a discount. If you are eligible for one of the listed discounts, please present the appropriate ID to the front desk staff. Discounts cannot be offered without verification of status. Referral accounts not eligible for discount.

Hospital Policy

By signing below, you understand that you are financially responsible for professional fees that are to be paid at the time services are rendered. You may be charged a fee for appointments that are missed or canceled with fewer than 24 hours' notice. We do not carry open accounts. We accept cash, checks (*under $100.00 with required information given*), Master Card, Visa, Discover, Care Credit, and Scratchpay. In cases where in-hospital, emergency care, or hospitalization is required, a deposit prior to treatment may be required. We reserve the right to require pre-payment for any estimated services. There is a monthly billing fee and 1.5% interest that will be charged on an account for a returned check or overdue balance until the balance has been paid in full. If an account becomes assigned to a collection agency, the undersigned agrees to pay a 25% collection fee, court costs, and attorney fees, as allowed by law. There is a $35.00 service charge for returned checks. If a check is returned, we reserve the right to no longer accept checks for payment on your account.

I, the undersigned, have read and understand the payment policy of Community Animal Hospital.

Signature: _____ Date: _____

*** Information is required to write a personal check**