Community Animal Hospital

Client Information Form

Rev: 4/17/23

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

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

Co-Owner or Spouse: _____ *Owner Driver's License: _____

Mailing Address: _____ *Above info required for check payments

Street Address (if different): _____

City, State, Zip: _____

Primary Contact Number: _____ Mobile Number? ❑

Alternate Contact Number: _____ Mobile Number? ❑

Additional or emergency contact: _____ Mobile Number? ❑

E-mail address: _____

Patient reminders will be sent by email or text message.

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? _____

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 our regular clients only and provide 10% off of services, excluding grooming and boarding up to a maximum discount of $100.00 per visit. Discounts are not offered on inventory items. Referral accounts not eligible for discount. 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.

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: _____

Community Animal Hospital

Patient Information Form

Owner Name: _____ Primary 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.

Pets are considered unvaccinated without prior history from another veterinarian. If you do not have records from your previous veterinarian, we may call with your permission.

Pet Information:

Pet's Name: _____

Species: _____ Breed: _____ Color: _____

Date of Birth/Age_____ Sex: _____ Neutered/Spayed? ☐ Age at S/N? _____

Previous veterinarian(s): _____

Dates your pet was last vaccinated: _____

Please check if we may call to collect records ☐

Is your pet microchipped or tattooed? _____ Currently on medication? _____

Additional Pet Information:

Pet's Name: _____

Species: _____ Breed: _____ Color: _____

Date of Birth/Age_____ Sex: _____ Neutered/Spayed? ☐ Age at S/N? _____

Previous veterinarian(s): _____

Dates your pet was last vaccinated: _____

Please check if we may call to collect records ☐

Is your pet microchipped or tattooed? _____ Currently on medication? _____

Additional Pet Information:

Pet's Name: _____

Species: _____ Breed: _____ Color: _____

Date of Birth/Age_____ Sex: _____ Neutered/Spayed? ☐ Age at S/N? _____

Previous veterinarian(s): _____

Dates your pet was last vaccinated: _____

Please check if we may call to collect records ☐

Is your pet microchipped or tattooed? _____ Currently on medication? _____

Community Animal Hospital

190 Broad Street
Dublin, VA 24084
(540) 674 – 1010

rev. 3/7/2024

DISCLOSURE FORM

(As required by amendment 54.1-3806.1 of the Code of Virginia)

Client's Name: _____

Pet's Names: _____

I, the undersigned, do hereby certify that I am the owner or authorized agent for the owner of the animal(s) listed above.

I am aware that Community Animal Hospital's regular business hours are

Monday thru Friday	7:30am – 6:00pm
Saturday	8:30am – 1:00pm
Sunday	CLOSED

Continuous medical care is not provided after hours or on holidays without added expense.

I, the undersigned, verify by signing this disclosure form that I understand there is no staff on duty except during regular business hours as posted at the door and in detail on this form.

Signed: _____ Date: _____

(Owner or authorized agent for owner)