HAPPY TAILS
VETERINARY HOSPITAL

Client In-take

Client Name _____ **Client Name (Co-Owner)** _____

Phone Number _____ **Phone Number (Co-Owner)** _____

Email Address _____ **Email Address (Co-Owner)** _____

Primary Address _____

Patient Information

Patient Name _____ **Date of Birth** _____ **Color/Markings** _____

Breed _____ **sex:** **Male** ☐ **neutered** ☐ **Female** ☐ **spayed** ☐

Basic Information

Does your pet have a microchip? **Y / N** **If so, then please provide the ID #** _____

Typical Food: (i.e brand, variety, wet, dry, etc.) _____

Which fits your pet living arrangement: **indoor** ☐ **outdoor** ☐ **both** ☐

Medical Information

Special Medical History: _____
Please bring any and all of your pet's previous medical records to your visit.

Does you pet have any known alleries or reactions to medication or food? **yes / no**

If you answer "yes", please specifiy: _____

Is your pet up to date on vaccines? **yes / no**

Is your pet on heartworm prevention? **yes / no** **brand name:** _____

Is your pet on flea and tick prevention? **yes / no** **brand name:** _____

Are you coming from a different doctor or hospital? **yes / no**

If yes, please provide the doctor or hospital: _____

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Getting to know your Pet

How would you describe your pet's reaction to going to the vet?

Is your pet on any chronic medication/supplements?

Please list the names and brands

Are there any veterinary procedures that made your pet particularly uncomfortable in the past or that seemed difficult for you or the staff to do? (nail trim, blood work, temperature check, ear exam, etc.)

Are there any special instructions related to your pet that would like us to know?

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Recurring Credit Card Payment Authorization

You authorize regularly scheduled charges to your credit card. You will be charged the amount indicated below each billing period. A receipt for each payment will be provided to you and the charge will appear on your credit card statement. You agree that no prior notification will be provided unless the date or amount changes, in which case you will receive notice from us at least 10 days prior to the payment being collected.

I _____ authorize **Happy Tails Veterinary Hospital** to charge my
(Cardholder's Name)

Credit Card indicated below for $_____ on the _____ of
(Amount $) (day)

each _____.
(week, month, etc.)

Billing Information

Billing Address _____ Phone # _____

City, State, Zip _____ Email _____

Card Details

☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Cardholder Name _____
Account/CC Number _____
Expiration Date ____ /____
CVV ____
Zip Code _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify **Happy Tails Veterinary Hospital** in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I acknowledge that the origination of Credit Card transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this Credit Card and will not dispute these scheduled transactions; so long as the transactions correspond to the terms indicated in this authorization form.

SIGNATURE _____ DATE _____
(Cardholder's Signature)

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24 Hour Cancellation & "No Show" Fee Policy

Recognizing that everyone's time is valuable, and the appointment time is limited, we ask that you provide a 24-hour notice if you are unable to keep your appointment. Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Happy Tails Veterinary Hospital in Pasadena, MD reserves the right to charge a non-refundable fee of $35.00 for each missed appointment, if it is not canceled within 24-hour notice. If it is your first appointment with Happy Tails as a new patient that has missed an appointment without 24-hour advance notice, the fee will be non-refundable of $65.00. If an emergency appointment is missed the non-refundable fee is $131.00.

"No Show" fees will be billed to the patient. This fee is not covered by pet insurance, the fee must be paid prior to your next appointment. Multiple "No Shows" within a 12-month period will result in termination from our practice.

Thank you for your anticipated cooperation.

By signing below, you acknowledge that you have received this notice and you understand this policy.

_____

Print, Last name, First name Date

_____

Signature

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VETERINARY HOSPITAL

Please include you favorite picture of your pet. Their photo will be linked to their medical records.

PET PHOTO CONSENT FORM

I, _____, hereby grant _____ permission to use any photographs taken of myself or my pet, in any and all of its publications, including website entries, without payment or any other consideration. I understand and agree that these materials will become your property and will not be returned. I hereby authorize to edit, alter, copy, exhibit, publish or distribute this photo for purposes of publicizing your programs or for any other lawful purpose.

In addition, I waive any right to royalties or other compensation arising or related to the use of the photograph. I hereby release rights to all claims, demands, and causes to action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf of my estate have or may have by reason of this authorization. In signing this consent, I give authorization to use my name and my pet's name and information as printed below.

_____
(Pet's printed name)

_____ _____
(Owner's Signature) (Date)

_____
(Owner's printed name)