Animal Care
At Twin Lakes Center

ACTLC
Registration Form

Client Information

Last Name:	First Name:	M.I.:
Mailing Address:		
City:	State:	Zip Code:
Preferred Phone Number:	Alternate Phone Number:	
Email Address:		
How did you hear about us? ☐Family/Friend - Please tell us who! Check all that apply ☐ Internet/Facebook		
Previous Vet Information:		

Patient Information

Pet's Name:	Species: ☐ Canine ☐ Feline ☐ Other	Color:
Breed:	☐ Male ☐ Female ☐ Spayed ☐ Neutered	Birthdate or Age:
Emergency Contact Name:	Emergency Contact Phone:	
Release of laboratory, radiology and/or vaccination records to other veterinary, boarding and/or grooming facilities: ☐ Yes ☐ No		

TREATMENT AUTHORIZATION

I confirm that I am 18 years of age or older, and that I am the owner (or authorized agent of the owner) for the pet listed above. With my signature, I authorize the veterinarians and staff of ACTLC to examine, treat, administer medications, and perform diagnostic, surgical procedures, and/or to hospitalize my pet if the doctor(s) deem it necessary for the health, safety or well-being of my pet. I understand that except in dire emergencies all treatments and procedures will be discussed with me prior to implementations. I acknowledge that I have read, understand and agree with the above information. I give authorization for ACTLC to provide detailed information concerning my pet's appointment(s), test results, and referral information to the phone number(s) I have listed on this registration form and/or my emergency contact in a life or death emergency. **INT** _____

FINANCIAL POLICY

I assume full financial responsibility for ALL charges incurred in the care of my pet(s). I understand that payment is due at time of services and that ACTLC does not bill for services rendered. Payments can be made in the form of cash, personal check (with proper identification), or accepted credit cards. In order to avoid misunderstandings, please let us know immediately if these terms are not satisfactory. I understand that I, as the owner or agent, am financially responsible to ACTLC for all charges relating to this patient. I have read and agreed to the treatment authorization. I have also read and accepted the financial obligations. **INT** _____

PHOTO RELEASE AUTHORIZATION

By submitting any photo(s) to ACTLC, you agree to the following: I certify that I am 18 years of age or older, and I am the sole owner of the photograph(s) I submit to ACTLC. I agree not to email any photograph(s) protected by copyright without the express permission of the owner of the copyright. I grant ACTLC the right to reproduce, distribute, publish, display, edit, and otherwise use the photograph(s) for express purpose of ACTLC social media pages. ☐ **I ACCEPT** ☐ **I DECLINE** **INT** _____

_____ _____

Signature Date