CLIENT INFORMATION SHEET

_____

Last Name First Name Significant Other

Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone #: (_____) _____

Secondary Phone #: _____

E-Mail: _____

Driver's License: _____/_____/_____

License # State Expiration

How did you find us? _____

PET INFORMATION

_____ _____ Male or Female/Spayed or Neutered

Name Age

_____ _____ Male or Female/Spayed or Neutered

Name Age

_____ _____ Male or Female/Spayed or Neutered

Name Age

PAYMENT POLICY: Payment is due at the time of services rendered. We do not carry open charge accounts. Deposits are required on extended boarding stays, major medical, surgical, and emergency cases. I agree to pay all costs for the collection of unpaid services. We accept the following forms of payment:
(Cash, Check, American Express, Discover, MasterCard, or Visa)

12 HOUR CANCELLATION AND NO-SHOW FEE POLICY: We reserve the right to charge a fee of **$30** for all missed appointments ("no shows") and appointments which without a compelling reason are not cancelled with a 12-hour advance notice. This fee must be paid prior to your next appointment. Multiple "no shows" in any 12-month period may result in termination from our practice. Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients.

Date: _____

Signature: _____

Printed Name: _____