

ADOBE PET HOSPITAL

-PLEASE PRINT-

Owner's Name: Mr./Mrs./Ms./Miss _____ Home Phone _____

Address _____ City _____ Zip _____

How did you first hear about us? _____ Email Address _____

Information for: Mr./Mrs./Ms./Miss (circle one)

Employer _____

Business Phone _____

Social Sec # _____ Driver's Lic # _____

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Employer _____

Business Phone _____

Social Sec # _____ Driver's Lic # _____

ADOBE PET HOSPITAL FINANCIAL POLICY:

Communication regarding finances is extremely important for good relations between client and staff. At the time of admission we communicate with the client by giving an estimate of expected fees. If therapy on your animal is changed, the estimate may need to be revised. A deposit may be requested at the time of hospitalization. Payment is required at the time services are rendered. Master Card, Visa, Discover, American Express, or approved checks with proper identification are all accepted. Please communicate with us any problems you might have with paying your bill.

The undersigned is the owner and/or responsible person for the animal being cared for and authorizes the attending veterinarian to perform medical, dental, or surgical treatment as his/her professional judgment deems necessary. The undersigned understands that there may not be supervision of the animal when the clinic is closed. The undersigned also accepts financial responsibility for services rendered on behalf of the patient and understands that payment is due in full upon release of patient from hospital.

WE ACCEPT THE FOLLOWING FORMS OF PAYMENT:
CASH CHECK VISA MASTERCARD DISCOVER AMERICAN EXPRESS

I have read and agree to the above terms and conditions:

Signature of Owner: _____ Date _____

Pet's Name _____ Species _____ Breed _____

Sex: M F OVH: _____ Neuter: _____ Color _____ Date of Birth _____

Last Vacc: **K9**: DHLPP/C _____ RABIES _____ BORD. _____ LYME _____ HWTest _____

FE: FVRCP _____ FeLV _____ RABIES _____ FIP _____ FeLV/FIV Test _____

Special Instructions: _____

MEDIC ALERT _____

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