NEW CLIENT FORM

Client Info

Owner:_____ ☐Hm_____

Co-Owner/Spouse_____ ☐Cell_____

Spouse Cell_____Spouse Wk_____☐Work_____

*Please check which phone you would like us to use as your primary contact number.

Address_____

City_____State_____Zip_____County_____

Email:_____Driver's License____ _____

Please check if you would like to receive any of the following via email? ☐Vaccine Reminders & Information Alerts ☐Newsletter

Employer:_____

Employer Address (used for referral program):_____

Referred by ☐Sign/Drove By ☐Website ☐Internet Search through_____

☐Personal Referral by_____

Pet Info

1. Name:_____ ☐Dog ☐Cat ☐Bird ☐Other_____

Breed:_____ Color:_____

☐Female ☐Female Spayed ☐Male ☐Male Neutered

Birth Date or Age:_____ Age pet obtained_____

Pet obtained from ☐Shelter ☐Friend ☐Breeder ☐Rescue group_____

Previous vet where past records can be obtained_____

2. Name:_____ ☐Dog ☐Cat ☐Bird ☐Other_____

Breed:_____ Color:_____

☐Female ☐Female Spayed ☐Male ☐Male Neutered

Birth Date or Age:_____ Age pet obtained_____

Pet obtained from ☐Shelter ☐Friend ☐Breeder ☐Rescue group_____

Previous vet where past records can be obtained_____

EXAMINATION & TREATMENT AUTHORIZATION and ASSUMPTION OF FINANCIAL RESPONSIBILITY

To maintain our high quality of care, Hartwood Animal Hospital is dependant upon payment of services at the time they are rendered. For this reason the hospital does not extend credit (bill). We accept cash, check (w/ID), VISA, & Mastercard. We will be glad to provide a treatment plan for services at any time. A deposit will be required prior to starting treatment for surgical and hospitalized patients.

I, the owner or authorized agent of the aforementioned pet(s), authorize the Doctors and staff of Hartwood Animal Hospital to examine and treat the above described pet(s) and to administer any medical, surgical treatments and/or tests, including sedation or anesthesia which is considered necessary based on findings during the course of examinations. I understand that any treatments performed will be with my full knowledge and consent except in emergency situations.

I assume responsibility for all charges incurred for services rendered to the patient. I understand there is a $35.00 service charge for returned checks that will be debited electronically from my account along with the face amount of the check and that after thirty (30) days unpaid accounts may accrue interest at the rate of 1.5% per month (18% per annum). If collection action is necessary on this account, I agree to pay all costs of collection (33% of the balance owed plus attorney fees), whether or not the suit is filed. The parties agree to the exclusive venue and jurisdiction of Stafford County, Virginia, for all matters arising from this agreement.

_____

Authorized Owner or Agent Signature **(must be 18 years or older)** **Date**