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GRANTS LICK
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Dr. Paul Garofolo
Dr. Mike Crowley
Dr. Steve Enzweiler

Dr. Kim Garofolo

Dr. Kate Middendorf
Dr. Jennifer Quammen
Dr. James Simpson

Welcome to our hospital. We look forward to serving you and your pet. Our office hours are **Monday, Tuesday, Wednesday and Thursday 8:00 AM – 7:00 PM, Friday 8:00 AM – 6:00 PM and Saturday 8:00 AM – 2:00 PM**.
•At times, it may be necessary to close the office early due to staff meetings, Doctor continuing education, or inclement weather. We do try to post this information ahead of time.

APPOINTMENT POLICY:
Appointments are seen by appointment only, since we also treat large animals on the farm. Appointments are seen by appointment time not arrival time. If you can not keep your appointment, please call ahead to cancel. We do charge an office call fee for missed appointments.

PRESCRIPTION OR FOOD REFILL POLICY:
We ask that you call ahead for all prescription refills and prescription pet foods. This would greatly help our staff to serve you in a timely manner. Our goal is to have records pulled, charted and prescriptions or pet food ready when you arrive. Also, due to limited space, we are not able to carry a large supply of prescription pet foods. We place weekly orders, so remember it is always a good idea to call ahead for all prescription pet foods.

PET MEDICAL RECORDS POLICY:
In accordance with the Veterinary Practice Act regarding the confidentiality of Patient Medical Records, a written authorization executed by the client is required in order for our clinic to release copies of your pet's medical records.

EMERGENCY POLICY:
In Case of an **AFTER HOUR EMERGENCY**, please call our office using one of the above numbers. A message on the answering machine will give you further instructions. After regular business hours, there is always a Doctor available for emergency consultations. Since there is no Doctor or staff on duty after regular business hours, some emergencies may be referred to the emergency clinic. The Doctor on call will let you know what the best options are for your pet's emergency. Our answering machine is set for "Emergency Calls" only. Please do not leave messages pertaining to appointment cancellations, billing questions, or etc… you will need to call the office during regular business hours.

BILLING POLICY:
Payment is expected when services are rendered. Due to the high cost of billing, it is our policy **NOT TO EXTEND CREDIT** for any routine office visits, vaccines, surgery, medicines, or pet food because we want to be able to provide the best veterinary care at the lowest possible cost to you. Clients are required to leave a deposit on pets that need to be hospitalized. The person that brings the pet in will be responsible for the bill. In case of an emergency, if full payment can not be made, all charges must be prior approved by the bookkeeper or Doctor. Any balance remaining after 30 days is subject to a minimum of a 1 ½ % service charge or a $4.00 monthly billing charge, whichever is greater. Service charges or billing charges may change without notice. We accept cash, checks, Visa, Discover, or MasterCard. **THERE IS A $50.00 CHARGE ON ALL RETURNED CHECKS.**

Our Doctors and Staff Thank You for entrusting us with you pet's health care.

PLEASE FILL OUT THE FOLLOWING FORMS AND PLEASE PRINT:

NAME: _____TODAY'S DATE: _____

HOME PHONE: _____ CELL PHONE #:_____

HOME ADDRESS:_____

CITY: _____ ST:_____ ZIP:_____

*EMAIL ADDRESS: _____
By providing your email address you can receive special discounts and get access to your own "Pet Portal" – a new service we provide that allows you to track your pets important health information

WORK PLACE:_____

WORK ADDRESS:_____WORK PHONE#:_____

CITY: _____ ST:_____ ZIP:_____

SPOUSE'S NAME:_____ SPOUSE'S CELL PHONE#:_____

SPOUSE'S WORK PLACE:_____

WORK ADDRESS:_____WORK PHONE#:_____

CITY: _____ ST:_____ ZIP:_____

FOR OFFICE USE ONLY – THIS PAPER WILL BE KEPT IN A LOCKED LOCATION.

ACCOUNT #_____

NAME: _____

DATE OF BIRTH: _____

DRIVER'S LICENSE#:_____

SOCIAL SECURITY#:_____

SPOUSE'S NAME: _____

SPOUSE'S DATE OF BIRTH:_____

SPOUSE'S DRIVER'S LICENSE#:_____

SPOUSE'S SOCIAL SECURITY#:_____

I AGREE TO PAY IN FULL FOR SERVICES RENDERED AND UNDERSTAND THAT ANY BALANCE REMAINING AFTER 30 DAYS IS SUBJECT TO A 1 ½ % SERVICE CHARGE OR A $4.00 MONTHLY BILLING FEE CHARGE, WHICHEVER IS GREATER. SERVICE CHARGES OR BILLING CHARGES MAY CHANGE WITHOUT NOTICE. ALSO, THERE IS A $50.00 CHARGE ON ALL RETURNED CHECKS.

I AGREE TO THE ABOVE CONDITIONS.

SIGNATURE:_____

DATE:_____