Scotts Valley Veterinary Clinic

Welcome to our hospital. So that we may become better acquainted, please complete the following.

Owner _____ Co-**Owner** _____
First Last First Last

Address

_____
Street City Zip

Mailing if Different_____

Telephone _____ _____ _____
Home Work Cell

Employment _____ _____
Employer Address

CDL#_____

How did you become aware of our hospital?
Yellow Pages _____ Sign_____ Web_____ Other (Specify) _____

May we thank a friend for recommending us? Name_____

TREATMENT AUTHORIZATION AND INFORMATION RELEASE

I hereby authorize Scotts Valley Veterinary Clinic (herein to be referred to as SVVC) to perform medical and initial diagnostic/surgical procedures on my pet as required for diagnosis and treatment. I understand that I can terminate treatment at any time by contacting the hospital staff.

In the event my pet is required to be transferred to the emergency clinic/specialty practice for further care/diagnosis or boarding at a boarding facility etc. I authorize my pet's records/radiographs and other pertinent findings/information be released to said parties. I understand that SVVC DOES NOT disclose my information to other third parties. In the event my animal transfers ownership; I authorize the release of medical information to the new owner upon request.

FINANCIAL POLICY

Payment is due at the time the services are rendered. In order to focus on our patients' needs, customer service and min imizing costs, we do not bill. A deposit is required for hospitalized cases and for all major surgical procedures. The balance is due upon discharge of the pet from the hospital. WE accept all major credit cards, cash and personal checks with proper identification.

In the unlikely event that a balance is to accrue, any balance over 30 days old will incur a $5.00 per month service charge AND an additional monthly interest rate of 1.5%

CANCELLATION POLICY

We require 24 hours notice of an appointment cancellation or change in order to utilize that appointment time for another patient. WE can usually fill a canceled appointment with a half day notice (the afternoon of the next day morning appointment or the morning of an afternoon appointment). The cancellation charge of $49.00 is applied at the discretion of SVVC when we are unable to fill an appointment without sufficient notice.

I understand as (the owner or agent) that I am financially responsible to SVVC for all charges relating to patients I present for treatment. I have read and agree to the treatment authorization, financial policy and cancellation policy.

SIGNATURE_____ DATE_____