
New Patient Information

Owner Name _____

Mailing Address _Street_____Apt #_____

_City_____State_____Zip Code_____

Home Phone _____ Cell Phone _____

Email (for reminders) _____

Emergency Number/Authorized Representative _____

Employer Company_____Address_____

Work Phone_____May we call you at work? Y/ N_____

Driver's License Number_____

Social Security Number _____

Owner's Date of Birth _____

**Payment Policy**

Payment is due at the time of your visit. We accept cash, personal checks with proper ID, Visa, MasterCard, Discover and Care Credit. Deposits are required for extensive medical/surgical/ and emergency issues that require hospitalization of your pet. **FULL PAYMENT IS EXPECTED AT THE TIME OF SERVICE**.

**Client Consent**

I am the owner, or representative of the owner over the age of 18, of the animal presented and have the authority to execute this consent. I authorize and direct the veterinarians at LaVale Veterinary Hospital to administer authorized treatment as needed on the basis of findings during the course of evaluation: to diagnose, prescribe, sedate/anesthetize, and perform therapeutic procedures and /or surgery as their judgement may dictate to be advisable for the patient's well-being. I understand I will be advised as to the nature of the procedures and the risks involved. I understand that no warranty or guarantee will be made as to the results or cure.

An estimate of the fees will be provided AT MY REQUEST for the initial assessment and treatment for the animal presented. I realize that actual expenses may differ from the estimate dependent on the patient's condition and length of stay in the hospital. LaVale Veterinary Hospital will try to contact me if emergency treatment is required. I also understand and will be responsible for expenses incurred in an emergency when I cannot be reached or there is no time to contact me. I will be fully responsible for monitoring the ongoing expenses and will be fully responsible for all expenses incurred through the animal's diagnosis and treatment. I understand that I assume responsibility for the animal's diagnosis and treatment. I understand that I **assume responsibility for the balance of all services rendered on a cash/credit card/ check basis at discharge with a 1.5% finance charge per month on any unpaid balance.**

Responsible Client/
Agent_____Date_____