

# PET MEDICAL CENTER AT APPLE TREE COVE

## OWNER REGISTRATION/FINANCIAL POLICY



### CLIENT INFORMATION

Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_\_  
Mailing Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_  
Physical Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_  
Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_  
Email Address \_\_\_\_\_ SSN \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Employer Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

### *Spouse, Partner or Authorized Agent*

Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_\_  
Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

How did you hear about us? Internet Yellow Pages Sign Referred by: \_\_\_\_\_

### PET INFORMATION

Name \_\_\_\_\_ Breed \_\_\_\_\_ Age \_\_\_\_\_  
Color \_\_\_\_\_ Gender: *Male Female* Spayed/Neutered? *Yes No*

Name \_\_\_\_\_ Breed \_\_\_\_\_ Age \_\_\_\_\_  
Color \_\_\_\_\_ Gender: *Male Female* Spayed/Neutered? *Yes No*

### FINANCIAL RESPONSIBILITY

Thank you for choosing Pet Medical Center as your pet's health care provider. We are committed to your pet's treatment being successful and you play an important role as well. Please understand that full payment of your pet's medical care is considered part of your pet's treatment plan. The following statement is our Financial Policy, which we require you to read and sign prior to any treatment.

We regret that Pet Medical Center is not able to extend credit. Payment for all medical services and products must be made at the time the services and products are provided. Please tell us how you prefer to pay:

*Cash/Check Credit Card (MC, Visa, American Express, Discover) CareCredit™*

Appointment times are reserved exclusively for your pet, so please help us serve you better by keeping all scheduled appointments. Any appointment changes require 24 hours notice. We reserve the right to charge for any missed appointments or sudden appointment changes that are not made within 24 hours of your scheduled appointment.

Any checks returned by your bank will be charged a \$40.00 administrative fee and we will no longer be able to accept a personal check as payment for medical services.

*Thank you for reading and understanding our Financial Policy. Please let us know if you have any questions or concerns before any treatment is performed on your pet.*

***By signing this form I assume financial responsibility for all medical services approved by me and performed by Pet Medical Center.***

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE