SCOTTS VALLEY VETERINARY CLINIC

Welcome. So that we may become better acquainted, please complete the following:

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

Mailing Address: _____
Street City Zip

Home Address (if different): _____
Street City Zip

Telephone Numbers: _____ _____ _____
Home Cell Work

Employment: _____

Driver's License #: _____ **Email:** _____

Do you have Pet Insurance? No: _____ Yes: _____ Company Name: _____

How did you become aware of our clinic?

Sign/Location: _____ Internet/Yelp: _____ Other (please 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 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 clinic staff.

In the event my pet may need to be treated at an emergency or specialty clinic, I authorize my pet's records/radiographs and any other pertinent information to be released to said parties. I understand that SVVC will not share my information with any third parties. And in the event my pet transfers ownership, I authorize the release of medical information to the new owner upon request.

FINANCIAL POLICY

Payment is due at the time services are rendered. In order to focus on our patients' needs, customer service and minimizing costs, we do not bill. A deposit may be required for hospitalized cases and for major surgical procedures. The balance (in full) is due when the patient is discharged from our clinic. 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 a 24 hour notice of an appointment cancellation in order to utilize that appointment time for another patient in need. A fee may be applied at the discretion of SVVC if a cancellation is made 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 policies above.

SIGNATURE: _____ **DATE:** _____