Client ID#____________

PAWS AND CLAWS VETERINARY HOSPITAL

(209) 832-4444
2630 S. Tracy Blvd. #110, Tracy, CA 95376

CLIENT INFORMATION:

NAME (LAST)_________________________________, (FIRST)_____________________________________

ADDRESS ____ APT./STE. #_________________

CITY_______________________________, STATE________________ ZIPCODE______________________

CELL PHONE #___________________________ ALTERNATIVE PH. #______________________________

DATE OF BIRTH____________________ EMAIL____

FORMER VETERINARIAN____

WHO REFERRED YOU?____

PATIENT INFORMATION:

NAME ________________________	NAME ________________________	NAME ________________________
SPECIES ______________________	SPECIES ______________________	SPECIES ______________________
BREED ________________________	BREED ________________________	BREED ________________________
COLOR ________________________	COLOR ________________________	COLOR ________________________
SEX __________________________	SEX __________________________	SEX __________________________
SPAYED/NEUTERED ______________	SPAYED/NEUTERED ______________	SPAYED/NEUTERED ______________
DOB/AGE ______________________	DOB/AGE ______________________	DOB/AGE ______________________

SIGNATURE: ____ DATE: _______________________

Client ID#___________

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Financial Agreement and Authorization:

I authorize treatment of the above named pet(s) and agree, irrevocable, that in consideration of the services to be rendered that I hereby obligate myself to pay the account in accordance with the regular rates of the provider.

As required by law you are hereby notified that a negative report reflecting on your credit reporting agency for collection, the undersigned agrees to pay actual attorney's fees and plus 30% service charge.

I authorize my employer to release employment information to the provider or the provider's agents. I acknowledge that this facility has audio and video monitoring and all phone calls can be recorded. There may be times when no personnel are on the premises. I affirm that I am 18 years of age or older and legally authorize to approve treatment/services.

Full payment required at time of service and final bill is upon release of the patient.

****NO CHECKS, APPLE OR GOOGLE PAY****

Deposit Policy:

Paws and Claws Veterinary Hospital reserves the right to require a deposit. Examples include new clients, surgeries, and specialty services, etc.

In the event of a cancellation with less than 24 hour notice, the deposit is non-refundable.

Specialty surgery cancellations with less than 24 hour notice, will be charged a cancellation fee which will be deducted from the deposit. The fee(s) will vary based on the type of surgery.

No Show Policy:

In the event that you are unable to make it to your scheduled appointment time, we ask that you notify us within 24 hours. We understand that there can be unforeseen circumstances, in which case, we ask that you notify the hospital as soon as feasibly possible.

If we are not notified of the cancellation and you are unable to make it to the scheduled appointment time, you may be subject to a no show fee.

SIGNATURE: ____ DATE: _____________________