ST ANNA VETERINARY CLINIC

CLIENT REGISTRATION FORM

FIRST NAME:_____ **MIDDLE:**_____ **LAST:**_____

DATE OF BIRTH:_____

MAILING ADDRESS:_____

CITY:_____ **STATE:**_____ **ZIP CODE:**_____

PRIMARY PHONE:_____ **SECONDARY PHONE:**_____

OCCUPATION:_____

EMPLOYER:_____

ADDRESS:_____

WORK PHONE:_____

EMAIL ADDRESS:_____

By providing us with your email address, you will be invited to sign up for PET PORTAL which will provide you with your pet's vaccination history, email reminders, and product promotions.

SPOUSE [ ] PARTNER [ ] CO-OWNER [ ]

NAME:_____

ADDRESS (if different from above):_____

Employer:_____

Work Phone:_____

CANCELLATION/NO SHOW POLICY

Please give a 3 hour notice to the clinic for any appointment you need to cancel. If 3 appointments are missed or appropriate time was not given for the cancellation, a $30 fee will be needed to make future appointments.

PROFESSIONAL FEES ARE TO BE PAID AT THE TIME SERVICES ARE PERFORMED.

Collection Agency Placement Policy: You are financially responsible for the timely payment of your outstanding bill per our payment policy. You will be responsible for any and all collection agency fees up to 33.33% of the amount placed with the collection agency. In the event we seek legal action for collection on your account, you will also be responsible for any and all fees associated with court costs, garnishments, and/or attorney fees.

It is understood that an estimate of charges will be given for services upon request. No guarantee or assurance can be made as to the results that may be obtained. Further, I realize that these charges may exceed a given estimate if complications arise. I understand that I will be contacted prior to treatment, if possible, should complications occur.

SIGNATURE:_____ **DATE:**_____