ANIMAL CLINIC LEESTOWN ROAD

NEW CLIENT FORM

Owner First Name: _____ Last Name: _____

Spouse/Significant Other: _____

Street Address: _____Apt#:_____City:_____State:_____Zip:_____

Email:_____

Phone #1: _____Phone #2: _____

PETS:

Name: _____ Species: (DOG/CAT) Gender: (MALE /FEMALE) (ALTERED /UNALTERED)

Breed: _____ Colors: _____ Birthday/Age: _____

Name: _____ Species: (DOG/CAT) Gender: (MALE /FEMALE) (ALTERED /UNALTERED)

Breed: _____ Colors: _____ Birthday/Age: _____

Name: _____ Species: (DOG/CAT) Gender: (MALE /FEMALE) (ALTERED /UNALTERED)

Breed: _____ Colors: _____ Birthday/Age: _____

***** Accepted Forms of Payment: All Major Credit Cards & Debit Cards, CareCredit, Cash, and Checks *****
ALL FEES ARE DUE AT THE END OF YOUR APPOINTMENT! UNPAID BALANCES WILL RESULT IN FORFEITURE OF RIGHTS TO RECORDS, AND FURTHER CARE BEING DENIED! WE DO NOT OFFER PAYMENT PLANS!!!

Client Agreement: *I understand that ACLR utilizes the services provided by the Fayette County Attorney for returned checks and all accounts sent to the county attorney are subject to additional fees and penalties. I also understand any balance that remains unpaid for any reason will be sent to a professional collection agency and I agree that I will be responsible for additional fees and penalties incurred to Animal Clinic Leestown Road for collections on this account, as well as interest accrued at 1.5% monthly (18% annum). Animal Clinic Leestown Road reserves the right to present past due accounts to small claims court in place of a collection service. I have read the above and understand the hospital payment policy. I acknowledge that I am the responsible owner of the pet(s) associated with the above name and represent all other owners. I assume responsibility for all charges incurred in the care of the animal. You must be 18 years or older to legally sign this consent.*

Signature of client responsible for pet(s): _____ Date: _____