Thank you for choosing **Center for Animal Health** for your veterinary needs. We are committed to providing our clients and patients with the best possible treatment and service. The following is a statement of our financial policy which we request that you read, agree to and sign prior to any treatment. A copy of this policy will be given to you if requested.

cfah
Center for Animal Health

CONSENT FOR MEDICAL CARE

Permission is granted to the doctors, employees, and contractors of Center for Animal Health to do such procedures as requested and as may be necessary to diagnose, treat, and care for the needs of my pet(s) from this day forward. I hereby give my permission to release case and patient information with photos and/or video so they may be used in specialty consultation/referral, teaching/continuing ed., forms, website, social media, broadcast, veterinary literature, and the like.

Signature _____ Date _____

FINANCIAL RESPONSIBILITY

Payment for Services

Payment is due at the time of service. Patients admitted for diagnostics and/or treatment require a deposit toward procedures in the amount of 50% of the estimated or anticipated fees. We accept cash for payment. Personal checks are accepted if you have provided payment security information as requested. For your convenience we accept Visa, MasterCard, Discover and Care Credit. **An office administration fee of 3% is applied to invoices when paying with debit or credit cards.**

Medical Fees, Estimates and Invoices

Estimates and updates on hospitalized patient bills are available upon request. Estimates provided by this office are a guideline only, and ultimately, invoices for services rendered, regardless of outcome, are the determinant of services due to be paid. Fees are subject to change without notice.

Pet Insurance

The balance for services is your responsibility, whether your insurance company pays or not. Your insurance benefit is a private contract between you and your insurance company and Center for Animal Health is not party to that contract. We do not bill your insurance company. It is your responsibility to know the policies of your insurance company. Center for Animal Health is not responsible for knowing what your insurance policy will and will not cover.

Missed Appointments

No charge will be made for rescheduling an appointment provided 24 hour notice is given. Please remember that your appointment time has been reserved for you. Fees may be assessed for clients with repeated missed appointments.

Returned checks

There is a service charge of $25.00 on all checks returned for insufficient funds. Interest and service fees will apply as with any other outstanding balance.

Interest and Service Fees

In the event that a balance remains unpaid after service has been rendered, interest will accrue at a rate of 1.5% per month, and a billing service fee of $4.00 will be applied to the outstanding balance at the time we create a monthly statement.

Collection

Any outstanding balance left unpaid after reasonable attempts by this office to ensure payment, shall be turned over to a collection agency without notice. Collection fees, interest and attorney fees will be added to the balance due and those will become the responsibility of the client of record.

Financial Consent

I acknowledge that, by signing below, I am ultimately responsible for bills incurred when presenting the pet(s) of record to Center for Animal Health for care, whether that guardianship has been assigned to others, or through implied assignment such as when my pet(s) are presented for care by a person other than me. I further agree to be fully responsible for total payment of procedures performed by this practice, including any treatment that is not a benefit of any insurance.

I certify that I have read, understand and agree to this policy.

Signature _____ Date _____

Welcome to Center for Animal Health

Thank you for giving us the opportunity to care for your pet(s).

ACCOUNT #_____VERIFIED_____CARD SENT _____DATE_____SCANNED _____DATE_____

OWNER INFORMATION

Owner: _____ Co-Owner: _____

Address _____

City _____ State _____ Zip Code _____

Email Address _____

Preferred Phone _____Secondary Phone _____

Employer(s) _____

In Case of an Emergency Contact Name & Number _____ _____

We prefer Cash or Checks for Payment. If you pay with a Credit or Debit card there is a 3% fee added to your bill.

If writing checks we need ONE of the following + your date of birth:

Social Security # ____-____-____ Driver's License # _____Date of Birth ____/____/____

Who was your PREVIOUS VETERINARIAN? _____

May we call them for records? _____

PATIENT INFORMATION	**Pet #1**	**Pet #2**	**Pet #3**
Name			
Breed(s)			
Neutered/Spayed			
Date of Birth			
Color(s)			

PET ORIGIN: ☐Non-breeder individual ☐Pet shop ☐Kennel/Breeder ☐Pet Refuge
☐Friend ☐Humane Society ☐Stray ☐Rescue

How did you come to know about us: ☐another doctor's referral, if so whom _____

☐our sign ☐internet ☐saw David Visser, DVM on WNDU ☐friend, if so whom _____

We will gladly prepare a written estimate if you desire. Please ask the receptionist, technician or doctor.
Professional fees are due at the time services are rendered. If the hospital allows other arrangements they must be made prior to services. If I should ever incur any indebtedness for this or any other animal, I hereby agree that all indebtedness will be paid within 30 days. All accounts carrying a balance will incur interest at 1 1/2% per month on the outstanding balance, with a minimum service charge of $4.00 per month. I understand that failure to pay any indebtedness will result in my accounting turned over for collection, and I will be responsible for any and all legal or other fees necessary for the collection of this account. I have read the above statement carefully, and I certify that the information I have given is correct.

_____ _____ _____ _____
Owner *Date* *Co-Owner* *Date*

please turn over