LOVINGSTON VETERINARY HOSPITAL

Jessica Ligon DVM

<u>NEW CLIENT INFORMATION</u>

Date:	
Name:	
Street Address:	
City, State, Zip:	
Cell Phone:	
Home Phone:	
Work Phone:	
Email Address:	
Employer:	

<u>Client Agreement and Authorization</u>

I hereby authorize the veterinarian to examine, prescribe for, or treat the pet described above. I assume responsibility for all charges incurred in the care of this animal. We accept cash, check, and all major credit cards. I also understand that these charges will be paid at the time of release and that a deposit may be required for surgical treatment. Returned checks are subject to a $50 returned check fee. All balances over 30 days are subject to a 2% monthly finance charge. If it becomes necessary to send your account to collections, you are responsible for all collection fees incurred. I am aware that the clinic's hours are 9:00 A.M. to 5:00 P.M. on weekdays, and on weekends it is open on the 2nd and 4th Saturday from 9:00 A.M. to 12:00 P.M. I understand that a doctor is not on the premises after hours and will not be present to treat my pets after hours. If continuous care is deemed necessary by thed doctor, animals ill need to be transported by the owner to the after-hours emergency hospital for care.

I HAVE READ THE STATEMENTS ABOVE AND AGREE TO THE TERMS STATED:

Signature: ____

Pet's Name:	
Age:	
Color:	
Breed:	
Sex:	

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Age:	
Color:	
Breed:	
Sex:	

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Sex:	

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*Please bring a copy of your pet's medical history with you (if applicable).