BERWICK ANIMAL HOSPITAL

5733 Ogeechee Road Savannah, GA 31405
912-232-4249 912-232-4259 fax

Date _____

CLIENT INFORMATION

Owner's name _____

Address _____ City _____ State _____ ZIP _____

Home phone _____ Work phone _____ Cell phone _____

Email Address: _____

Place of employment _____

By giving us your email address, you will be able to receive vaccine/test reminders and have access to request appointments, prescription refills, boarding reservations, and more online.

Do you qualify for a discount? If so, please provide identification. **Military** _____ **Senior Citizen** _____

How did you become aware of our clinic?
Drove by _____ Yellow Pages _____ Previous client _____ Personal referral (Whom may we thank?) _____

Co-Owner _____ Relation _____

Home phone _____ Work phone _____ Cell phone _____

In case of your absence, is there anyone other than the above mentioned who may authorize treatment of your pet?

Name _____ Number _____

PATIENT INFORMATION ** Reverse for additional Pets**

Name:	Name:
Breed:	Breed:
DOB/Age:	DOB/Age:
Color:	Color:
Previous Vet/Office:	Previous Vet/Office:
Allergies:	Allergies:
Special Diets/Meds:	Special Diets/Meds:
Sex: M / F Neutered/Spayed? Y / N	Sex: M / F Neutered/Spayed? Y / N

Treatment Authorization and Information/Photo Release:

I hereby authorize the staff of Berwick Animal Hospital to render any treatment which is deemed necessary to my pet(s) health while in custody of the hospital. I understand that in the event of any unusual or emergency circumstances, the staff will make every attempt to contact me or my designated representative before, if time permits, proceeding with treatment. I authorize release of any information concerning my pet's health and care to other parties working with or in treatment of our animals. I grant to Berwick Animal Hospital the right to take photographs my pet, and to copyright, use and publish the same in print and/or electronically.

Financial Policy:

Payment is due as services are rendered. For hospitalized cases, a deposit is required in advance. The balance is due upon discharge from the hospital. You may pay by cash, accepted credit cards, or ask us about getting approved for Care Credit. In order to avoid misunderstandings, please let us know immediately if these terms are not satisfactory.

In the event payment is not made at the time of service, it is our policy to apply a service charge to accounts with a balance over 30 days old. A service fee of $3.00 and 1.5% of the outstanding balance will be charged to your account monthly if not paid in full. All returned checks will incur a charge of $25.00.

I understand that I (the owner or agent) am financially responsible to the applicable practice(s) for all charges relating to this patient. I have read and agree to the treatment authorization. I have also read and accept the financial obligations. I also agree to pay for all expenses incurred to collect the debt including, but not limited to; attorney fees, collection agency fees and rebilling fees.

Signature: **Date:**