Manor Veterinary Hospital

Bonnie M. Carter, DVM

Client Information

Today's Date: _____

Name: _____ Spouse/Partner: _____

Mailing Address: _____

City, State: _____ Zip Code: _____ County: _____

Home Phone: _____ Fax Number: _____

Work Phone: _____ Cell Phone: _____

Spouse Cell: _____Spouse Work: _____

Email Address: _____

Place of Employment: _____

Employer Address:_____

May we contact you at work? Yes/No Spouse? Yes/No

Preferred Method of Contact: Cell Home Work Email

SS#_____ **OR** Driver's License #: _____

(These items will be used for collection purposes and/or if a check is written for services.)

How did you find us? _____

If you were referred to us by someone, please put their name above so we may thank them!

TREATMENT AUTHORIZATION/PAYMENT AGREEMENT

I, the undersigned, do hereby certify that I am the owner (or duly appointed authorized agent of the owner) of the described animal(s). I hereby authorize the license veterinarians of Manor Veterinary Hospital and technicians functioning under the direct supervision and direction of said veterinarians, to perform such medical or surgical procedures, anesthesia and/or other procedures they shall deem necessary and appropriate, including, but not limited to, the administration of such drugs and pharmaceuticals deemed necessary and appropriate. I agree to accept full responsibility for the payment of all services rendered. I understand that payment is due, in full, at the time of service and that no payment plans are approved without consent of the practice manager. Should we have to place your past due account with a collection agency/attorney you will be responsible for any and all collection fees and service charges accrued in the pursuit of the unpaid debt. I also understand that Manor Veterinary Hospital reserves the right to require a deposit at the time of drop off for any pet that will be left in our facility for medical care. I hereby declare that I have read this Treatment Authorization/Payment agreement and agree to its terms. I also understand that I may receive a copy of this authorization for my records.

SIGNATURE_____ DATE _____

By:___