



Bear Valley Veterinary Care Center

PATIENT & CLIENT INFORMATION FORM

Thank you for giving us the opportunity to care for your pet. As an AAHA accredited hospital, our goal is to provide compassionate and thorough health care for cats and dogs through education and advanced medical care. You and your pet are our highest priority. We value your devotion to their health and well-being.

In order that we may better serve you, please complete the following:

Your Name (First) (Last) Spouse/Other Caregiver Name (First) (Last)

Address Apt # City Zip Code

Primary # (Cell, Home, Work?) Secondary # (Cell, Home, Work?)

Spouse Primary # (Cell, Home, Work?) Spouse Secondary # (Cell, Home, Work?)

Occupation Employer OK to call at work? Y / N / Emergency Only

Email Address Spouse Email Address (This is so you can receive copies of your pet's lab work, report cards, reminders, and occasional informational emails.)

Pet's Name Breed

Male / Female Neutered / Spayed Birth Date or Approx. Age How long owned?

Color Does your pet take any medications?

Where Obtained? Pet Store Shelter Breeder Friend/Neighbor Other

Date of last veterinary visit Name/Phone of last Veterinarian

I authorize Bear Valley Veterinary Clinic to request previous medical care records from any/all previous providers. (initial)

Reason for leaving your last veterinarian

How did you hear about Bear Valley Veterinary Clinic?

Sign / Drive by Web Site Yellow Pages Recommendation

Who may we thank?

Bear Valley Veterinary Clinic is proud to be accredited by the American Animal Hospital Association (AAHA) for more than 25 years. For more information about our accreditation go to www.healthypet.com Have you heard of AAHA before? Yes Yes, and it plays a role in my choice of Veterinarian No

ALL FEES ARE DUE AT THE TIME THE SERVICES ARE RENDERED, Please review and sign financial policy. I authorize treatment of my pet by the staff and doctors of Bear Valley Veterinary Clinic and confirm that I am at least 18 years of age.

Client Signature

Drivers License Number

Bear Valley Veterinary Care Center  
FINANCIAL POLICY

*Acknowledge each item by initialing, then sign at bottom*

\_\_\_\_\_ **Payment is always due in full at the time services are performed.**

\_\_\_\_\_ We cannot release hospitalized pets from the hospital, or release medications dispensed, until the final bill for hospitalization or the current patient visit has been paid.

\_\_\_\_\_ We can not sell food, medications, or other items "on account".

\_\_\_\_\_ We accept **Visa, Mastercard, American Express, Discover, and Care Credit** when you present these cards for payment.

\_\_\_\_\_ We accept **cash** payments.

\_\_\_\_\_ We are happy to accept personal checks if they can be guaranteed. There is a \$30 fee on returned checks.

\_\_\_\_\_ We are happy to accept telephoned-authorized credit card payments when you are able to provide all of the necessary information including credit card number, expiration date, security code, and billing address.

\_\_\_\_\_ We promote the use of **Pet Insurance**. Payment is due in full at the time services are performed, but we will be happy to keep claim forms in order to expedite your prompt payment from the insurance company.

\_\_\_\_\_ We do not extend credit or bill for services. All open invoices are sent to collections after 45 days.

\_\_\_\_\_ We cannot extend further services to clients with outstanding balances.

\_\_\_\_\_ **Dog-walkers, pet-sitters, neighbors, and other alternate care-givers** must accept financial responsibility on the above terms before we can accept your pet for medical care. Due to identity theft concerns, ideally we should not keep your credit card information "on file" to use as needed in the care of your pet. However, if you would like to take responsibility of pet care costs in these situations please contact us for further discussion.

\_\_\_\_\_ Deposits are required for hospitalized pets and major surgical procedures.

\_\_\_\_\_ A \$40 fee will be assessed for all "no shows" of medical appointments or \$75 for each missed surgical appointment. Please provide us with the courtesy of a phone call within 24 hours of your appointment if you are unable to make your appointment.

\_\_\_\_\_ If you would like an estimate before services are performed, we'd be happy to provide one, but ultimately it is your responsibility to ask about the costs of services performed.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_