FLORENCE VETERINARY HOSPITAL NEW CLIENT FORM

THANK YOU FOR PROVIDING US WITH THE FOLLOWING INFORMATION

OWNERS NAME _____ OWNERS DOB_____

SOCIAL SECURITY NUMBER **OR** DRIVERS LICENSE NUMBER _____

HOME ADDRESS _____

CITY/STATE/ZIP_____

HOME PHONE _____

CELL PHONE _____

EMAIL ADDRESS (for reminders) _____

WORK PLACE/WORK PHONE _____

SPOUSES NAME _____ SPOUSES DOB _____

Payment is expected at the time of services. Any balances which are unpaid will be subject to an 18% APR accruing thirty days after time of service, or a monthly billing fee of $4.00, whichever is greater. A fee of $50.00 will also be applied to NSF checks. NSF checks will be turned over to the county attorney if not covered in a timely manner. Any account 90 days past due, with no attempt at payment, will be turned over to a collection agency.

SIGNATURE _____ DATE _____