

The Doctors and staff welcome you to

STEVENSON VETERINARY CLINIC

Your Name _____ Spouse _____

Home Phone _____ Cell _____

Email _____

Mailing address(PO Box) _____

Physical address (if different) _____

Your Employer _____ Phone _____

Spouse's Employer _____ Phone _____

Your Driver's License _____

Spouse's Driver's License _____

OUR PAYMENT POLICY

All professional fees are to be paid, in full, at the time of service or when patient is released from our care unless prior arrangements are made.

WHICH METHOD OF PAYMENT will you be using today? Cash _____ Check _____

Visa _____ MC _____ Discover _____

I the undersigned, agree to assume:

- * all collection costs pertaining to all animals, including reasonable attorney fees in connection with any returned check or credit card return/cancellation or open account balance.

- . A returned check fee of \$30.00

I/we the undersigned, now and from this date forward, assume all responsibility for any and all animals brought in by me or others on my/our behalf. I authorize the veterinarian(s) and staff to provide medical, dental and surgical procedures or whatever treatment is deemed appropriate.

Signed: _____ Date _____