



Animal Place Veterinary Hospital

13818 Georgia Ave | Silver Spring, MD 20906 | Phone 301-603-1223 | Fax 301-603-9419

Date _____

Owner's Name _____ Spouse _____

How would you like us to address you? _____

Address _____

Ste/Apt # _____ City _____ Zip _____

Telephone: Home _____ Cell _____ Work _____

Please circle the number you would like us to call first.

Email Address: _____ EMAIL ALL REPORTS ONLY YES NO

Employer's Name / Address: _____

How did you learn of our clinic? **Online Advertisement** If yes, which one _____

Print Advertisement If yes, which one _____ **Social Network** If yes, which one _____

Recommendation If yes, by whom? _____ **Sign** YES NO

    **Pet Information**    

Name _____ Dog Cat Other _____

Breed _____ Color _____ Date of Birth ____/____/____ or Age _____

Sex: Male Neutered **Other Pets:** _____

Female Spayed _____

Please check any symptoms or problems you have noticed about your pet

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Limping | <input type="checkbox"/> Shaking Head |
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Eyes Bloodshot | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Thirst or Increased Urination |
| <input type="checkbox"/> Behavior Problems | <input type="checkbox"/> Gagging | <input type="checkbox"/> Scooting | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Coughing | <input type="checkbox"/> Lack of Appetite | <input type="checkbox"/> Scratching | <input type="checkbox"/> Weakness |

No Symptoms – Routine Wellness Visit Other _____

Pet's current medications _____

Previous veterinarian(s) where past records could be obtained if necessary _____

Authorization

I hereby authorize the veterinarian to examine, prescribe for or treat the above described pet. I am over the age of 18 and I assume full financial responsibility for all charges incurred in the care of this pet. I also understand that these charges will be paid at the time services are rendered and that a deposit may be required for surgical/medical treatment. In the unfortunate event collection procedures are required to collect an outstanding account balance, I will be responsible for the cost of a collection agency, attorney, and/or court costs.

All pets must be up to date on vaccines to be admitted to The Animal Place Veterinary Hospital. I give permission to The Animal Place Veterinary Hospital to administer vaccines which are necessary: DHP, Rabies and Kennel Cough for dogs and FVRCP and Rabies for cats.

The Animal Place Veterinary Hospital is not staffed 24 hours a day and there may be times my pet is left unsupervised.

Signature of owner _____ Date ____/____/____

Driver's License Number _____ State _____ Exp ____/____/____

**Checks returned will be subject to a \$25.00 return check fee, as well as any additional fees necessary.



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Financial Policy

Thank you for choosing Animal Place Veterinary Hospital. Our primary mission is to deliver the best and most comprehensive veterinary care available for your pet. An important part of the mission is making the cost of optimal care as easy and manageable for our clients as possible by offering several payment options. Animal Place Veterinary Hospital requires payment in full at the end of your pet's examination and/or at the time of discharge.

Payment Options:

You can choose from:

- Cash, Check, Visa[®], MasterCard[®], American Express[®] or Discover Card[®]
- Convenient Monthly Payment Plans¹ from CareCredit[®]
 - Allow you to begin treatment today and pay over time
 - Available for any treatment amount
 - Can be used repeatedly - for your entire family - without having to reapply¹

For some treatments or hospitalized care, a deposit may be required. Healthcare plans requiring comprehensive care of \$400 or more, will require a 50% deposit to begin your pet's treatment.

Additional Policy Information:

Animal Place Veterinary Hospital charges \$25 for returned checks. For clients with pet insurance, we are happy to provide you with the necessary documentation to submit a claim to your insurance carrier.

If you have any questions, please do not hesitate to ask. We are here to provide the best veterinary care available for your pet.

By signing below, you agree to the above stated terms:

Client/Owner Signature

Date

Client/Owner Name (Please Print)

Pet Name

Breed

¹Subject to credit approval