Cibolo Small Animal Hospital, Inc

3929 Cibolo Valley Dr Suite 200, Cibolo, TX 78108

OFFICE USE ONLY

Alert _____

S/A _____

CLIENT INFORMATION FORM

MUST BE COMPLETED BEFORE EXAM

My account will be set up as follows:

Business Name (If applicable): _____

Owners Name: _____

(Last) (First) (Middle Initial)

Address: _____

City: _____ State: _____ Zip Code: _____County:_____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Additional Owner(s) to add to account: _____Phone: _____

Email Address: _____

Employer: _____

Address: _____

Business Phone: _____

PAYMENT IN FULL IS EXPECTED AT TIME OF SERVICE

Please indicate your preferred form of payment: _____Cash _____Check _____Credit Card

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How did you learn about our hospital? _____

Number of household pets: _____Dogs _____Cats

I grant Cibolo Small Animal Hospital representatives and employees the right to take photographs of me and/or my pet, and to copyright, use and publish the same in print and/or electronically, with or without my name and for any lawful purpose, including, for example, such purposes as publicity, illustration, advertising and Web content.

_____The above may take photos of me and/or my pet _____The above may NOT take photos of me and/or my pet

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Professional fees are to be paid at the time services are rendered. There will be a $25.00 fee on all returned checks. Please read carefully. Signature is required before exam or treatment.

I hereby consent and authorize Cibolo Small Animal Hospital, Inc., its doctors and representatives to administer such treatment, diagnostic, surgical, and anesthetic procedures as they deem necessary. None of the above will be held liable or responsible in any manner whatsoever, under any circumstances, for the care, treatment or safekeeping of animals, as it is understood, I assume all risks.

I hereby certify that I have read and fully understand the above authorization for medical and/or surgical treatment. I also agree that no guarantee or assurance has been made as to the results that may be obtained. Furthermore, I assume financial responsibility for all charges incurred to patient, consent to release of medical information, and authorize direct payment to Cibolo Small Animal Hospital.

This practice's financial policy is that payment is due at the time services rendered.

I understand that I am financially responsible for payment of all bills for veterinary services, late charges, and collection costs.

_____ _____

Client Signature Date