

WELCOME TO SUMMIT VETERINARY HOSPITAL

Client Name: _____ **Spouse's Name** _____

Mailing Address: _____

Number Street City ZIP

Street Address

Required: _____

Number Street City ZIP

Telephone: _____

Home Cell Spouse's Cell

Email: _____

Employer: _____

CDL# _____

DOB: _____

All fees are due and payable at the time of the visit or when the animal is discharged. We accept VISA, MASTERCARD, personal checks and cash. For returned checks a \$24.00 service charge will be charged back to the account in addition to the amount of the check and any bank charges and collection fees. There will be a 1.5% per month or 18% per year finance charge added to all balances that are 30 days past due in addition to a \$5.00 statement fee added to the unpaid balance each month. If the account goes to collection, an additional 30% of the unpaid balance will be added to the account to cover collection agency costs.

I understand that I am financially responsible for all charges or services that I have requested or authorized.

Signature of responsible party _____

Date _____

How did you hear about us? _____