

## **YOUR FINANCIAL OBLIGATIONS TO CASPER VETERINARY ASSOCIATES**

The truth in Lending Law and Consumer Credit Code requires that all clients be aware of their financial obligations for services rendered and methods of payments accepted.

### **PLEASE READ AND SIGN**

1. Payment is required at time of services or release of patient from hospital. We accept all major credit cards, cash, check, money order, and Care Credit.
2. All returned checks are assessed a \$30.00 returned check fee.
3. All emergency patients will be on a cash only basis (no credit will be extended). Emergency fees start at \$80.00 and are payable at time of service.
4. All boarding bills will be paid for when the animal goes home. Partial prepayment of 50% may be required on stays longer than 10 days.
5. All rabies observations will be paid in advance of quarantining the animal.
6. All routine services and retail items will be paid at time of service.
7. Charges can be estimated prior to treatment. Please don't hesitate to ask for a written estimate.
8. Financing *may* be arranged for those charges over \$200.00 with APPROVED CREDIT.
9. Your signature indicates that you have read and understand your financial obligations to Casper Veterinary Associates, P.C. I further agree that in the event of non-payment of any amounts due under this agreement I will pay interest thereon at the rate of 1.75% per month and pay all reasonable attorney fees and court costs that may be incurred. I agree that in the event this agreement is assigned to an agency for collection I promise to pay an additional collection fee of 35% of the unpaid balance due.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

PRINTED NAME: \_\_\_\_\_



# WELCOME

Thank you for giving us the opportunity to care for your pet. We'll be happy to answer any questions you have about your pet's health. To insure the best care possible, please fill out this form completely. Thank you.

## REGISTRATION

Today's Date: \_\_\_\_\_

Owner's Name: \_\_\_\_\_ Spouse/Other \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

DOB: \_\_\_\_\_ Email: \_\_\_\_\_ (Get vaccination reminders paperless)

SS #/SIN: \_\_\_\_\_ Drivers License #: \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

## PET HEALTH HISTORY

Pet's Name: \_\_\_\_\_ Age or DOB: \_\_\_\_\_ Species:  Canine  Feline

Sex:  Male  Female -Spayed/ Neutered  Yes  No Breed: \_\_\_\_\_ Mixed

Color: \_\_\_\_\_ Medication currently taking: \_\_\_\_\_ Diet: \_\_\_\_\_

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

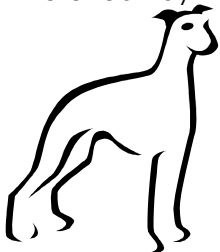
- |  |   |  |                  |
|--|---|--|------------------|
| <input type="checkbox"/> Bad Breath                | <input type="checkbox"/> Lack of Appetite | <input type="checkbox"/> Increased thirst and/or urination |                  |
| <input type="checkbox"/> Behavioral Problems       | <input type="checkbox"/> Limping          | <input type="checkbox"/> Weight Problems                   |                  |
| <input type="checkbox"/> Bleeding Gums             | <input type="checkbox"/> Loss of Balance  | <input type="checkbox"/> Other: _____                      |                  |
| <input type="checkbox"/> Breathing Problems        | <input type="checkbox"/> Scooting         | Vaccination History (Date Given)                           |                  |
| <input type="checkbox"/> Coughing                  | <input type="checkbox"/> Scratching       | Canine   | Feline           |
| <input type="checkbox"/> Diarrhea                  | <input type="checkbox"/> Seems Depressed  | Rabies: _____  | Rabies: _____    |
| <input type="checkbox"/> Eye, Bulging or bloodshot | <input type="checkbox"/> Shaking Head     | Distemper: _____   | Distemper: _____ |
| <input type="checkbox"/> Gagging                   | <input type="checkbox"/> Sneezing         | Bordetella: _____  | FIP: _____       |
| <input type="checkbox"/> Vomiting                  | <input type="checkbox"/> Weakness         | Lyme: _____  | Leukemia: _____  |

Reason for today's visit: \_\_\_\_\_

I hereby authorize the veterinarian to examine, prescribe for, or treat the above-described pet. I assume responsibility for all charges incurred in the care of the animal. I understand that these charges must be paid at the time of services/release and that a deposit may be required for hospital treatment.

Signature of Owner/Agent: \_\_\_\_\_

Preferred Payment Method: Cash Check Credit Card Care Credit Other: \_\_\_\_\_



Dedicated to Pets and People  
2060 Fairgrounds Road \* Casper, Wyoming 82604 \* 1-307-266-1660

