



*Manzanita Animal Hospital*  
 2323 E. Detroit Avenue  
 Kingman, Arizona 86401  
 928 - 753 6138

## CLIENT INFORMATION SHEET

Client Name \_\_\_\_\_

Spouse Name/Significant other \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Work phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Spouse Cell Phone \_\_\_\_\_

E-mail address \_\_\_\_\_

Driver's License \_\_\_\_\_ Date of Birth \_\_\_\_\_

May we keep a copy of your Driver's License on file for check & credit card use? Yes  No

Senior Citizen (65 or older) Yes No

Referred by: Sign Internet Google Facebook Yellow Pages Friend/other

May we contact your previous veterinarian to obtain a copy of all medical records?

Yes No Veterinarian & Phone number \_\_\_\_\_

Pet's Name \_\_\_\_\_

Species: Canine Feline Equine Other

Sex: Male Female Neutered: Yes No Breed: \_\_\_\_\_

Color: \_\_\_\_\_ Age/D.O.B \_\_\_\_\_

Vaccines Current: Yes No Done At: \_\_\_\_\_

Medications: \_\_\_\_\_

Pet's Name \_\_\_\_\_

Species: Canine Feline Equine Other

Sex: Male Female Neutered: Yes No Breed: \_\_\_\_\_

Color: \_\_\_\_\_ Age/D.O.B \_\_\_\_\_

Vaccines Current: Yes No Done At: \_\_\_\_\_

Medications: \_\_\_\_\_

I understand and agree to the financial policy set forth on the reverse side of this document, that payment is due at the time of service.

**\*\*\*\*\*Please review and sign financial policy on the next page\*\*\*\*\***

Client Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_



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## Financial Policies

Our pet care facility receives no support from charitable organizations or the Government. Only by receiving prompt payment for our services can we maintain the well equipped, staffed, and stocked facility that our patients and clients deserve. Thus, the following is the financial policy of this business.

- All fees are due and payable upon completion of services. Manzanita Animal Hospital **DOES NOT** offer “in house” credit.
- **PAYMENT METHODS:** CASH, CHECK, DEBIT, CREDIT CARD and CARE CREDIT
  - (Care Credit is a medical credit card with a quick, simple online application and instant notification of approval.)
- **CHECK POLICY:** In the event that you pay services by check and the check is returned for any reason you will be billed for these services again plus a \$25.00 returned check fee. By providing your check as payment, you authorize Manzanita Animal Hospital to use information from your check to make an electronic fund transfer from your account. Funds may be drawn from your account the same day as your payment, and you will not receive your check back from your bank. (We return your check, immediately at the conclusion of the transactions.)
  - **If payment is returned unpaid, you authorize EZCHECK to debit from your account an electronic fund transfer a fee of \$25.00.**
- **INSURANCE POLICY:** Manzanita Animal Hospital will not contact your pet insurance carrier on your behalf. It is the policy holder’s responsibility to make sure the account balance is paid in full and to present, verify, and submit all necessary forms back to your insurance company for reimbursement.
- **PAST DUE ACCOUNTS:** All past due accounts will be assessed charges for billing and finance costs. *If your account is turned over for collections, you agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 40% of the debt, and all costs, and expenses, including reasonable attorneys fees, we incur in such efforts.*
- **I understand that if my pet is hospitalized, I will be required to leave a deposit in the amount of 50%-100% of the estimated costs. All additional fees will be collected upon completion of services.**
- **APPOINTMENT CANCELLATIONS:** A \$75 Fee will be assessed to any account who fails to notify Manzanita Animal Hospital of their cancellation of surgical appointments at least 24 hours prior (10 a.m. the day before) to the appointment. A \$35 fee will be assessed to any account who fails to notify Manzanita Animal Hospital of their cancellation of an examination appointment no less than 24 hours prior to that appointment.

My signature below indicates that I have read, understand, and agree to comply with ALL the financial policies set forth in this document.

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