FINANCIAL RESPONSIBILITY AGREEMENT:

I hereby authorize West Gate Veterinary Hospital Professional Staff to examine, treat, and utilize procedures or test deemed necessary for my pet(s) to ensure the best possible care.

I assume responsibility for all charges incurred to my pet(s). **I understand that payment is due at the time services are rendered and/or at the time of the pet's discharge**. If I am unable to pay in full, I must notify West Gate Veterinary Hospital prior to treatment.

Should my pet be hospitalized or require extensive treatment, I will receive an estimate of the cost and **before I leave I agree to pay the required 50% of the estimated cost** and pay the remaining balance when the pet is discharged.

A non-payment will be considered default after (5) five days overdue and a late charge of 18 % APR monthly will be applied to all unpaid balances plus any collections and/or reasonable attorney fees that incurred in an attempt to collect this debt. Acceptable payment types are: Cash, Checks, Debit Cards, Visa, Master Card, Discover, American Express, and Care Credit Cards.

In accordance with the privacy act, I understand my rights for privacy and that personal information will not be released without my consent.

I certify and authorize West Gate Veterinary Hospital to disclose the necessary information required, for the continuing good health of my pet(s), with other veterinarians, specialists, and other related third parties.

I certify that all the information is correct and I have read and understand the above information and agree to the payment terms.

To prevent the spread of infectious diseases and parasites, all hospitalized and boarded animals, to include baths, must be current on all vaccines and free of external and internal parasites. I authorize the staff to provide vaccines and parasite control as needed for my pet(s).

Owner's Signature: ________________________ Date: ___________

Patient(s) Registration:

Pet One:

Name: ____________________ **Species:** Canine ☐ Feline ☐ Other: _______

D.O.B. or Age Breed Color/Markings

Gender: **Male:** Neutered ☐ Not Neutered ☐ **Female:** Spayed ☐ Not Spayed ☐

Is your pet on any special diet or medications?

Are there any previous health/behavior issues we should be aware of?

Vaccine History: Not Current ☐ Current ☐ (Please provide vaccination records)

Pet Two:

Name: ____________________ **Species:** Canine ☐ Feline ☐ Other: _______

D.O.B. or Age Breed Color/Markings

Gender: **Male:** Neutered ☐ Not Neutered ☐ **Female:** Spayed ☐ Not Spayed ☐

Is your pet on any special diet or medications?

Are there any previous health/behavior issues we should be aware of?

Vaccine History: Not Current ☐ Current ☐ (Please provide vaccination records)

Pet Three:

Name: ____________________ **Species:** Canine ☐ Feline ☐ Other: _______

D.O.B. or Age Breed Color/Markings

Gender: **Male:** Neutered ☐ Not Neutered ☐ **Female:** Spayed ☐ Not Spayed ☐

Is your pet on any special diet or medications?

Are there any previous health/behavior issues we should be aware of?

Vaccine History: Not Current ☐ Current ☐ (Please provide vaccination records)

Dr. Adam Carter D.V.M.
Dr. Brett Brooks D.V.M.
Dr. Caroline Brown D.V.M.

Thank you for choosing our hospital. We take pride in ourselves in offering high quality medical care and emphasize preventive medicine. We look forward to serving you and caring for your pet's needs. Please complete this form so we can accurately enter this information into our files. **(To open an account with us, you must be at least 18 and provide a photo I.D. such as a driver license or state I.D. for check writing purposes only.)**

Owner(s)

Last Name ________ First Name ________ SS# (For check writing only) ________

Street Address ________ City ________ State ________ Zip Code ________

Home Phone Number ________ Cell/Pager Number ________ Driver License # & State ________

D.O.B. (Required) ________ Occupation ________ Work Number ________ E-mail Address (pet correspondence only) ________

Spouse's First Name ________ Last Name ________ Occupation ________

Work Number ________ Cell/Pager Number ________ S.S. # (For check writing only) ________

How did you hear about us? (Circle one please)

Phone Book Our Sign Internet Other: ________ Referral From: ________

Today's Date: ________