



Thank you for giving Sisters Veterinary Clinic an opportunity to care for your beloved pet. So that we may become better acquainted please complete the following:

Primary Contact/Owner (1 only) _____	Phone Number _____
Mailing Address: _____	City _____ State _____ Zip _____
Physical Address (if different from mailing): _____	City _____ State _____ Zip _____
Email Address: _____	

Second Owner: _____	Relationship: _____	Phone: _____
Email: _____		

Emergency Contact name: _____ Phone: _____

(Will only be contacted in case of emergency)

How did you choose our Clinic? (circle one and/or write below) Internet Newspaper Friend

Whom may we thank for referring you to us? _____

IT IS OUR POLICY TO PROVIDE YOU WITH AN ESTIMATE OF CHARGES FOR ANY CASES WHERE IN-HOSPITAL TREATMENT, SURGERY, OR HOSPITALIZATION WILL BE PROVIDED. A DEPOSIT PRIOR TO TREATMENT WILL BE REQUIRED DEPENDING ON THE AMOUNT OF ESTIMATE. THE BALANCE AFTER DEPOSIT AND ALL OTHER SERVICES ARE DUE AND PAYABLE ON PET'S RELEASE.

Our credit and collections policy is a necessary albeit uncomfortable part of assuring the financial resources needed to maintain quality medical services to our patients. In order to establish optimal relations with our clients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial policies of this office. Payment is due at the time of service. We accept Cash, Check, Visa, MasterCard, Care Credit, Apple Pay and Samsung Pay.

I verify to be the owner or agent of this pet and I grant permission to Sisters Veterinary Clinic to vaccinate, treat, perform any recommended/requested, or emergency medical care to my pet. I agree to pay for services rendered when my pet is discharged to me. Any past due amounts will be subject to interest at the rate of 2% per month.

Signature _____ Date _____