

Carriage Hills Animal Hospital Referral Services

Thank you for giving us the opportunity to care for your pet which we feel is a member of your family.
Please help us to serve you better by providing the following information:

Are you new to Carriage Hills Animal Hospital? () Yes () No

How did you hear about us?

_____ Doctor Referral _____ Friend of Family Member (If so, who may we thank?) _____
_____ TV/Pet Vet _____ Phone Book _____ Website _____ Previous Client

Who is your referring veterinarian?

Doctor's Name: _____ Clinic Name: _____

CLIENT INFORMATION:

Owner _____	Spouse _____
Street Address _____	Street Address _____
City _____ State _____ Zip _____	City _____ State _____ Zip _____
Home Phone _____	Home Phone _____
Cell Phone _____	Cell Phone _____
Work Phone _____	Work Phone _____
Email _____	Email _____

Please help us prevent identity theft by providing the following and a **picture ID (Required)**

Driver's License # _____	Driver's License # _____
Social Security # _____	Social Security # _____
Date of Birth _____	Date of Birth _____
Emergency Contact _____	Phone Number _____

List all parties that you authorize to use this account. **(Required)**

Name _____	Name _____
Name _____	Name _____

PLEASE SEE REVERSE SIDE

PATIENT INFORMATION: Please list any pet that will be receiving referral services

1. Pet Name _____ Sex: M ____ F ____ Spayed ____ Neutered ____
Species (Cat, Dog, Other) _____ Breed _____ Age ____ Color _____

2. Pet Name _____ Sex: M ____ F ____ Spayed ____ Neutered ____
Species (Cat, Dog, Other) _____ Breed _____ Age ____ Color _____

List name of anyone other than yourself who has permission to pick up your pet. **(Required)**

Name _____	Name _____
Relationship _____	Relationship _____

All Fees Are Due at the Time of Service:

For your convenience, we accept cash, checks, Visa, MasterCard, Discover, American Express, and Care Credit. We can provide a written estimate any time at your request. There will be a \$30.00 service charge for any check returned unpaid. Failure to arrange payment for your account will result in the referral to our collections agent or in the event of your failure to make good any returned check, your account will be turned over to the Montgomery County District Attorney's Office for collection.

I/we, the undersigned, give prior express consent to Carriage Hills Animal Hospital, its employees and agenst, to contact me/us at any/all phone numbers given, including cell phoen number, for the purpose of treatment and/or concerning payment.

I/we acknowledge that no guarantees have been made as to the effect of examinations or treatments. I/we, the undersigned, agree the fee(s) charged are a legal and lawful debt and I/we agree to pay said fees, including the cost of collection (33.33%), attorneys fees and court cost if such be necessary and waiving now and forever any right to claim exemption under the consitution and laws of Alabama, or any other state.

Responsible Party: _____ Date: _____

Spouse/Other responsible party: _____ Date: _____

OFFICE USE ONLY

Account # _____ Doctor _____ Check-in Receptionist _____