NORTH SUFFOLK ANIMAL CLINIC
WELCOME TO OUR PRACTICE!!

Thank you for giving us the opportunity to care for your pet. Please take a moment to share some important information we will need as we support your pet's needs today and in the future.

PLEASE PRINT IN ALL SPACES.

OWNER'S NAME: _____ SPOUSE/OTHER: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PRIMARY PHONE NUMBER: _____ SECONDARY PHONE: _____

WOULD YOU LIKE TO RECEIVE TEXT MESSAGE REMINDERS/COUPONS? □ YES □ NO

IF YES, WHICH PHONE NUMBER WOULD YOU LIKE TO RECEIVE THESE AT? _____

E-MAIL: _____

HOW DID YOU HEAR ABOUT US: □Recommendation □Google □Sign □Facebook □Yelp □NSAC Website □NextDoor □ Event

IF RECOMMENDED, WHO CAN WE THANK? _____

PLEASE LIST ALL INDIVIDUALS AUTHORIZED TO REQUEST TREATMENT FOR YOUR PET(S): *must be 18 and older*

1) _____ 2) _____ 3) _____ 4) _____

Release of Information for Media or Website Publication

After an explanation of its intended use, I authorize the staff at this veterinary practice to release my pet's photographs and pet's first name to use with the following media entities: Facebook, Instagram, NSAC Website (Please cross through any that you do not authorize.)

I understand that this information may be used in the print media, on a brochure or on the website of this veterinary practice. I, the undersigned, agree not to file any claim for revenue or lawsuit for damages against this veterinary practice with respect to the release of this information.

_____ _____

Signature of Owner or Authorized Agent Date

PET HEALTH HISTORY:

Pet's Name	Cat	Dog	Other	Birthdate	F/M	S/N	Breed	Color

Previous Veterinarian: _____

I hereby authorize the veterinarians at North Suffolk Animal Clinic to examine, prescribe for, and treat the above described pet(s). Any animal admitted or hospitalized shall receive the necessary diagnostic tests and treatment to ensure proper medical care. I agree to pay for all services rendered and medications, goods, and supplies when purchased. I understand that a deposit may be required for surgical or medical treatment. All accounts not paid within 30 days will be subject to a late charge of 1 ½% per month (18% per annum) on the unpaid balance and billing charges in the amount of $3.00 per month. In the event of default, the undersigned further agrees to pay any or all collection agency, court cost and attorney fees in the amount of 33 1/3% of the total due when turned over for collection. These fees are due without any relief whatever from valuation or appraisement laws. This contract extends to all additional pets brought in at a later date. **ALL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED.** A $35.00 charge is made for all returned checks.

I understand the doctor hours are from 8am – 12pm and 2pm – 6pm Monday through Friday and 8am – 2pm on Saturday. I understand that at all other hours there may not be a veterinarian providing continuous care.

By my signature below, I hereby agree to all of the above and acknowledge the receipt of a copy of this agreement (upon request).

Signature of Owner or Agent: _____ **Date**: _____

North Suffolk Animal Clinic
5622 Bennetts Pasture Rd.
Suffolk, VA 23435
(757) 483-3800

Disclosure Statement

Client # _____

Name: _____

Address: _____

_____

Telephone:

Primary- _____

Secondary- _____

Work- _____

Other- _____

I understand that the office hours are from 7:30am to 6:00pm Monday thru Friday and 7:30am to 2:00pm on Saturday.

I understand the doctor hours are from 8am – 12pm and 2pm – 6pm Monday through Friday and 8am – 2pm on Saturday.

I also understand that there may not be a veterinarian on duty providing continuous care during all office hours.

I understand that there is no office staff or a veterinarian on duty or on call before or after specified hours above, as well as on holidays.

I certify that I have read the above information by signing below and that this form is to be permanently electronically filed in my clinic record.

Client Signature Date