Animal Hospital

Owner and Patient Information

Owner Name: _____ **Spouse/Co-Owner:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Primary Cell: _____(text reminders) **Spouse/Co-Owner Cell:** _____

Primary Email: _____

Patient Name: _____ **Date of Birth/Approx Age:** _____

Species: _____ **Breed:** _____ **Color(s):** _____

☐Male ☐Neutered ☐Female ☐Spayed

Is your pet microchipped? ☐No ☐Yes #_____

Previous veterinary contact information, if known _____

If you have your pet's medical history and/or vaccine history, please email those to records@ssvet.com

Any allergies to vaccines? ☐No ☐Yes If yes, which one(s) _____

On any medications or special diet? ☐No ☐Yes If yes, which one(s)_____

Do you have insurance for this pet? ☐No ☐Yes If yes, which one _____

I hereby authorize Saratoga Springs Animal Hospital and attending doctors to perform procedures as deemed necessary or advisable to maintain my pet's health-- including, but not limited to, physical examination, diagnostic testing and/or administering pharmaceutical agents. I understand that the administration of any pharmaceutical agents or the performance of any medical procedures can result in adverse reactions or events.

I hereby agree and consent to being contacted by telephone on any number belonging to me. I agree that such methods of contact may include the use of text messages and/or an automated dialing device--some or all of which may result in data charges. I also understand and agree that such contact(s) may be initiated by Saratoga Springs Animal Hospital and/or by any third-party engaged by Saratoga Springs Animal Hospital-- including but not limited to third-party debt collectors and that the purpose(s) of such contact may include things such as appointment reminders, misc. communications and attempts to service and/or collect any amounts owed. I also consent to receiving email communications from the same entities and for the same purposes.

I take full responsibility for payment of any charges incurred for treatment to my pet. I understand that I am financially responsible for all charges at the time services are rendered. I understand that a deposit may be required for any surgical treatment.

I understand and agree that if payment in full is not made as required, then in addition to all other amounts that may be due or remedy that may be sought, I will be required to pay a collection fee of up to 40% of the principal amount (as allowed by §12-1-11 of the Utah Code Annotated). I further agree to pay all other costs of collection and/or enforcement including but not limited to court costs, reasonable attorney fees, and interest (both pre-and post-judgment). Any interest due hereunder shall be calculated at 18% per annum and may compound as frequently as daily.

For your convenience we accept: Cash, Visa, Mastercard, Discover and Care Credit.
We do NOT accept checks or American Express.

_____ _____

Signature of Owner or Authorized Agent **Date**