

Welcome To Our Practice

Best Friends' Veterinary Hospital

Victoria Mary Hollifield, DVM

Client Information

Name: _____
Last First

Address: _____
Street

City State Zip

Phone: _____
Home Cell Work

Email Address: _____

How did you hear of us/Referred by: _____

Pet Health History

Pet's Name: _____ Breed: _____

Sex: _____ Spayed/Neutered? YES NO Date of Birth/age: _____

Obtained/Purchased from: _____

Other pets in the house: _____

Symptoms your pet is demonstrating:

- | | |
|---|---|
| <input type="checkbox"/> Appetite loss | <input type="checkbox"/> Loss of balance |
| <input type="checkbox"/> Behavioral changes | <input type="checkbox"/> Scooting |
| <input type="checkbox"/> Breathing problems | <input type="checkbox"/> Scratching |
| <input type="checkbox"/> Coughing | <input type="checkbox"/> Shaking Head |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Sneezing |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Thirst |
| <input type="checkbox"/> Eye disorders | <input type="checkbox"/> Urination increase |
| <input type="checkbox"/> Gagging | <input type="checkbox"/> Vomitting |
| <input type="checkbox"/> Gums Bleeding | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Limping | <input type="checkbox"/> Other _____ |

Prior Surgeries: _____

Prior Illnesses: _____

Current Medications your pet is taking:

Special Notes/Other Comments: _____

PLEASE BE SURE TO FILL OUT ALL 4 PAGES

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Release Form

I hereby consent and authorize you to receive, prescribe for, treat, or operate upon:

Pet's Name: _____ **Age** _____ **Sex** _____ **Breed** _____

Description: Color and markings: _____

You (Veterinarian) are to use all responsible precautions against injury, escape or destruction of the animal(s), but you (Veterinarian) will not be held liable or responsible in any manor whatsoever, for any circumstance, on account of the care, treatment or safe keeping of the animal(s) described, or otherwise in connection therewith, as it is thoroughly understood that I (the owner/agent) assume all risk.

After five (5) days from written notice to the undersigned (owner/agent) at the address below is mailed to remove animal(s), it will be considered abandoned and may be disposed of, or destroyed, as you (Veterinarian) deem best.

It is further understood that you so doing does not relieve me (undersigned owner/agent) in any way from paying all costs of your (Veterinarian) services and the use of your (Veterinary) hospital, including, but not limited to, the cost of keeping.

After carefully reading the above, I fully understand the terms and conditions stated herein.

Signed: _____

Date: _____

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Financial Policy

Thank you for choosing Best Friends' Veterinary Hospital as the veterinary clinic for your pet. We are dedicated to the overall good health of all our patients.

In order to facilitate an increasing number of patients and to keep our services at the same high level of quality, we are no longer able to extend credit out of our office. Please understand that full payment is due at the time of the service. We realize every person's financial situation is different and, for this reason, we provide the following payment options:

Payment Options

- ***Cash or Check:*** We accept payment by cash or check at the time of service.
- ***Credit Card:*** We accept Visa, MasterCard and American Express and Discover
- ***Care Credit:*** In an effort to offer our clients more personalized financial arrangements, we are happy to introduce the Care Credit Health Systems. If you wish to take advantage of this payment plan, which will enable you to make low monthly payments, please see the front desk for an application.
- ***We do not offer hospital charge accounts. All balances must be paid in full at time of service.***

I have read, understand and agree to the above, Financial Policy.

Responsible Party's Signature

Driver's License Number

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Missed Appointment Policy

At **Best Friends' Veterinary Hospital**, your scheduled appointment time is reserved just for you and your pet. We try not to overbook appointment times in order to provide excellent veterinary care and to be sure we have sufficient time to adequately examine your pet and to discuss your pet's condition and treatment options in detail with you.

We will make every effort to accommodate your scheduling needs. In return, we ask that you help us by keeping your scheduled appointments, arriving on time and notifying us a minimum of twenty-four (24) hours in advance if you are unable to do so. When we receive advanced notice of cancellation, we are able to avoid lost revenue and misspent employee time, which keeps our overhead down and our fees reasonable. More importantly, we are able to accommodate other patients needing care. Failure to comply with this policy will necessitate the assessment of the following fees:

- **First missed appointment:** Our staff will call to ensure you and your pet are all right and to reschedule your appointment.
- **Second missed appointment:** You will receive a letter stating this is your second missed appointment and that you have been charged a missed appointment fee (\$50.00)
- **Third missed appointment:** A letter will be mailed informing you that you have now missed three appointments and you have been charged another missed appointment fee (\$50.00)
- **Further missed appointments:** Further missed appointments will require immediate payment of our Standard Fee for Doctor's Visit (\$51.05/dogs and cats or \$68.10/exotics). **This fee must be paid prior to scheduling any future appointments.**

Please sign below that you have read and understand this policy

Sign: _____

Date: _____