

BLACKHORSE ANIMAL HOSPITAL

DR. FRED SCHNEIDER & DR. ELBERT DERRICK

NAME _____ HOME PHONE _____
Last First

MAILING ADDRESS _____
Street City Zip

WORK # _____ DRIVER'S LICENSE # _____ MOBILE/ PAGER # _____

EMPLOYER _____
Name Street City Zip

SPOUSE/ CO-OWNER _____ PHONE # _____
Last First

WORK # _____ DRIVER'S LICENSE # _____ MOBILE/ PAGER # _____

EMPLOYER _____
Name Street City Zip

PREVIOUS VETERINARIAN: _____ PHONE # _____

REFERRED BY _____
(name of person, yellow pages, sign, mail, etc.)

WE EXPECT PAYMENT IN FULL WHEN SERVICES ARE RENDERED.

I hereby authorize Blackhorse Animal Hospital to examine, treat, prescribe for, or perform surgery upon the described pet(s). I also consent to the administration of anesthetics as is necessary. Furthermore, I agree to pay fees for services that are rendered at the time the pet is discharged from the hospital or when service is otherwise terminated. Blackhorse Animal Hospital will notify the owner of the date on which the animal is to be released from the hospital. It is then the owner's, or an authorized agent of the owner's, responsibility to call for and pay all accrued charges on the animal within 10 days after written or verbal notification. After this time, if there is no contact, then the animal may be considered abandoned and disposed of humanely. I further understand that veterinary services are provided during the nighttime as necessary, on the judgment of the veterinarian in charge. Continuous presence of qualified personnel may not be provided at all times.

The Financial Policy continues on the back of this page.

SIGNATURE OF OWNER OR RESPONSIBLE AGENT

DATE

Thank you for giving Blackhorse Animal Hospital the opportunity to care for your pet!

Clinic use only- updated: _____