



## New Client Registration

Date: \_\_\_\_\_

Owner's Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Employer/Occupation: \_\_\_\_\_

Employer Phone Number: \_\_\_\_\_

Primary Number: \_\_\_\_ Home \_\_\_\_ Work \_\_\_\_ Cell Email Address: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_

By adding a co-owner, you are granting them full ownership rights to your pet(s) as outlined in the caregiver consent form on the next page.

Co-Owner Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Co-Owner Employer/Occupation: \_\_\_\_\_

Employer Phone Number: \_\_\_\_\_

Crater Road Veterinary Hospital occasionally uses email and text communication for vaccine reminders and to confirm appointments. Upon registration, you will receive an email that will link you to your online portal. You are able to opt out if you do not wish to receive notifications.

**We love social media!** Do we have your permission to share your pet(s) image and story on social media and/or our website? Your name and personal information will never be shared.

\_\_\_\_ Yes, I authorize Crater Road Veterinary Hospital to share my pet(s) photo and story

\_\_\_\_ No, I do not authorize

**Financial Policy:** All fees are due and payable at time that services are rendered. I agree to pay Crater Road Veterinary Hospital all costs incurred at time of service. There is a \$55 charge for no show appointments and appointments not rescheduled/cancelled 24 hours prior to appointment time. **Beginning May 1st** there will be a 3% processing fee for Visa, Mastercard, American Express and Discover card transactions.

**Payment methods:**

- Cash
- Card: Visa, Mastercard, American Express, Discover
- Care Credit: a convenient monthly payment plan option (Subject to credit approval)

**Return Policy:**

Prescription medications are non-returnable and their sales are final. Prescription diets have a palatability guarantee and can be returned within 30 days of purchasing. Any non-prescription items that are returned, within 30 days of purchase, will be credited to the client's account.

**Estimates:**

We are happy to provide estimates for all services. It is the client's responsibility to request an estimate prior to services rendered.

**Billing:**

We charge 18% interest on all outstanding account balances older than 30 days. If arrangements are not upheld or your check is returned for any reason and the balance becomes 60 days past due, your account will be turned over to our collection agency or attorney for collections. You agree to be responsible for all attorney fees at 33 and 1/3 %, plus cost and any additional collection fees.

**Deposits:**

Treatment plans or hospitalized care with an estimated cost of \$500 or more, requires a deposit of 50% to begin your pet's treatment.

**Insurance:**

For clients with pet insurance, we are happy to provide you with the necessary documentation to submit a claim to your insurance carrier upon request.

**Safety of our Team, Clients and Patients:**

We strive to always keep you and your pet safe while at Crater Road Veterinary Hospital. In doing so, please follow these rules.

- All dogs are required to be on a leash and secured by their owner. Please avoid having your pets interact with other pets in the hospital/lobby.
- All cats are required to be in a carrier.
- Please inform staff if your pet has a history of aggression and /or severe anxiety

I have read and fully understand the policy and procedures regarding being a client of Crater Road Veterinary Hospital. I understand that I am financially responsible for the care/treatment that I request for any patient now or in the future. By signing below, I am acknowledging and agreeing to the above terms.

**Signature:****Printed Name:**

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## Caregiver Consent Form

The purpose of this form is for approval and the authorization of agents other than yourself (i.e. spouse, partner, adult child, etc.) to bring your personal pet(s) in for service to be performed by Crater Road Veterinary Hospital.

I, \_\_\_\_\_, hereby appoint any agent listed below as my attorney and financial agent to make any and all decisions for me concerning all care and/or medical decisions needed for my pet(s). I accept financial responsibility for the actions/decisions of my authorized agent and agree to pay any and all costs of care rendered by Crater Road Veterinary Hospital or its employees that were authorized by my agent. I hereby release and hold blameless Crater Road Veterinary Hospital and its employees from any and all liability for any action or omission taken at the direction of any authorized agents.

**This consent shall remain valid until I expressly revoke it in writing.**

### Authorized Agent #1

Name: \_\_\_\_\_

Contact #: \_\_\_\_\_

Relationship to owner: \_\_\_\_\_

### Authorized Agent #2

Name: \_\_\_\_\_

Contact #: \_\_\_\_\_

Relationship to owner: \_\_\_\_\_

In the circumstance that someone other than myself or an authorized agent needs to bring my pet(s) in for care, I agree to be available by phone immediately upon their arrival and throughout my animal's appointment at Crater Road Veterinary Hospital and understand that no treatments will be administered until my consent is given. I understand that payment is due at time of service, whether my pet(s) is/are brought in by myself or by an authorized agent.

**Signature:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_

## **Virginia Veterinary Disclosure Form:**

**Crater Road Veterinary Hospital is open and has staff members present at all times during the following hours:**

**Monday:** 8:00 am - 6:00 pm    **Tuesday:** 8:00 am - 6:00 pm    **Wednesday:** 8:00 am - 6:00 pm

**Thursday:** 8:00 am- 6:00 pm    **Friday:** 8:00 am- 6:00 pm    **Saturday:** 8:00 am- 12:00 pm

**Sunday: Closed**

### **Doctors are seen by appointment only**

Outside of office hours and on holidays when our office is closed, doctors and/or staff check on, medicate, feed and water patients on an intermittent basis. During these times there is **NO** in house continuous medical staff care.

**I have been made aware of the staffing hours**

**Signature:** \_\_\_\_\_