Old Mill Veterinary Hospital
91 Lawson Road, Leesburg, VA. 20175
Telephone (703) 779-2903 Fax (703) 779-7440

ACCREDITED PRACTICE AAHA AMERICAN ANIMAL HOSPITAL ASSOCIATION

CLIENT INFORMATION

Date:_____ Social Security # _____(for check writing purposes)

Home Telephone (_____) _____ E-Mail _____
(e-mail is for Pet Portals)

Owner's Name _____ Spouse/Other _____
(Person responsible for financial obligations)

Cell Phone _____ Cell Phone _____

Address _____ City _____ State _____ Zip _____

Employer _____ Employer Telephone # _____

Emergency Contact Person _____ Local Telephone # _____

How did you first hear about us? Yellow Pages _____ Brochure/Mailing _____ Internet _____Other _____

Individual, someone we may thank? _____

PATIENT INFORMATION

Species Canine/Feline/Other	**Name**	**Breed**	**Color**	**DOB** (age)	**Sex**	**Altered**	**Distemper**	**Rabies**	**Other Vax**

Is your pet(s) currently protected against heartworm disease? Yes / No Product? _____
Is your pet(s) currently protected against fleas/ticks? Yes / No Product? _____

Old Mill Veterinary Hospital (OMVH) is dependant upon your payment of fees to maintain our high quality of patient care. The Hospital does not extend credit (bill) and you are responsible for all fees for products and services rendered. We will be glad to provide an ESTIMATE FOR SERVICES at any time.

AUTHORIZATION for EXAMINATION, TREATMENT and ASSUMPTION of FINANCIAL RESPONSIBILITY

I, the undersigned, authorize the veterinarian(s) and their staff to examine the patient specifically described and identified above and to administer any medical, surgical treatments and/or tests, including sedation or anesthesia which is considered necessary based on findings during the course of examinations.

I assume responsibility for all charges incurred for services rendered to the patient. I understand there is a $30 service charge for returned checks and that unpaid accounts may accrue a minimum of $11.00 late fee or 1.50% of balance, whichever is greater after thirty (30) days and for each month thereafter until the balance is paid. If collection action is necessary on this account, I agree to pay any and all costs associated with collecting this account, including collection fees and reasonable attorney's fees.

_____ _____
Signature of Owner or Responsible Agent (18 years or older) Witness (OMVH Employee)
Date _____