3714 St. Rt. 47
Sidney, Ohio 45365
Phone 937-492-6536
Fax 937-497-1582
16200 County Road 25A
Anna, Ohio 45302
Phone 937-693-2131
Fax 937-693-3422

Welcome To Our Clinic!

Owner's Name: _____ **Spouse Name:** _____

Address: _____

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

Cell Phone: (_____) _____ - _____ **Home Phone:** (_____) _____ - _____

E-Mail Address: _____

Driver's License Number/State Issued: _____/_____ **Exp. Date:** _____

How Did You Hear About Us? (Check One):

□ Business Sign □ Internet □ Facebook □ Yellow Pages □ Client Referral

Referred By: _____

How Would You Like to Receive Communications?

□ Text _____-_____-_____ **□ Email** _____

Patient Information

Name: _____ **Date Of Birth:** _____ **Breed:** _____

Species: □Cat □ Dog □ Other Sex of Pet: □ Male □Female □ Spayed/Neutered

Has your pet been seen by a veterinarian? □ Yes □ No If yes, Which Clinic?: _____

Were vaccinations completed? □ Yes □ No Vaccines Received: _____ **Date:**_____

I understand full payment is due at the time services are completed. Please feel free to discuss treatment options, as well as cost, with your pet's doctor. At any time during your pet's treatment, a written estimate can be provided at your request. There will be a $40 fee for any returned checks; re-billing service charges of 2% may be added to account balance if not paid in full. If Tri-County Veterinary Service Inc. should require an outside service to collect a past due amount, all reasonable finance charges and collection fees will be the responsibility of the pet owner.

Signature of Owner: _____ **Date:**_____

Tri-County Veterinary Service, Inc. has developed a list of policies to better fulfill the needs of our patients and to benefit their healthcare. Please check each box as you read. Thank You!

□ **1. If you are fifteen or more minutes late for your appointment, you must reschedule.**

□ **2. If you miss three appointments without calling to reschedule or cancel your appointment, it will cause the dismissal of medical care in this office and the practice will not be responsible for any medical/legal liabilities.**

□ **3. Legally it is your responsibility to keep all scheduled appointments with this office.**

□ **4. You are responsible for giving us correct personal information as it changes.**

□ **5. <u>You are responsible for payment in full for all services rendered in this office at the time it is rendered,</u> unless prior arrangements have been made with management or the doctor. We accept cash, check, Mastercard, Visa, Discover, American Express, Scratchpay, and Care Credit.**

□ **6. There will be a service charge of $40.00 for all returned checks.**

□ **7. All accounts past due 30 days, will be charged an accrued interest late fee.**

□ **8. Any account turned over to a collection agency will be charged an additional charge of 30% of the total bill due.**

I have read and understand the above policies and understand that breaking any of these policies can result in dismissal from this practice.

Signature of Client: _____ Date: _____

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