Wicomico
VETERINARY HOSPITAL

Client Account Form

Owner's First and Last Name: _____

Address: _____ **City**: _____

State:_____ Zip:_____ Employer: _____

Home Phone # _____ Cell Phone # _____

Work Phone # _____ E-Mail _____

How did you choose our Hospital for the care of your Pet? (Referral)

We **DO NOT** double book appointments - your appointment time is reserved exclusively for you and your pet. Please be considerate of others - if you miss your appointment, we will be unable to care for another patient in your pet's place. **All missed appointments, or those cancelled within 24 hours of the scheduled appointment time WILL BE CHARGED A MISSED APPOINTMENT FEE.**

LATE ARRIVALS: We kindly ask that you be considerate of others appointment times. If you arrive late for your appointment, we will be unable to remain on schedule for our other patients. If you arrive more than 10 minutes late for your pet's appointment, we will need to reschedule the appointment for a different day and or time. Thank you for your understanding in this matter.

A $35.00 fee is assessed for any check that is returned for any reason. All dishonored checks are forwarded to the **Wicomico County District Attorney's Office for criminal prosecution.**

Driver's License: State: Social Security Number:

Co-Guardian's License: State: Social Security Number:

FEE: I understand that I can receive a written fee treatment plan if I request one. I understand that a final fee will be based on actual services rendered, and agree to pay the full amount due at the time services are rendered or of the animal's release from the Hospital, including any boarding fees. Should the Hospital have to institute collection proceedings to recover any amount owed by me, I agree to pay all costs of such collection proceedings, including any legal fees incurred.

PAYMENT IS DUE IN FULL AT THE TIME SERVICES ARE RENDERED

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I understand that if I do not pay this account as agreed, the account is subject to costs of collection, attorney fees, and including interest (any balance that is carried over a period of 30 days will accrue a monthly service fee of 1.5% or 18% per annum). Return check fee is $35. I understand that the hospital staff will provide a treatment plan of current and anticipated charges any time I request one. I am requesting that veterinary care be provided for pets presented by me or my agents. I understand that I am financially responsible for all services provided. By submitting this form I agree to the payment terms above.

Signature of Owner Authorized Agent: _____ Date: _____

Print Name:_____