Office Use Only	
Account #:	
Date:	ID Verified:

Healing Hearts Animal Hospital
280 West 4800 South
Murray, Utah 84107
(801) 281-3900

Client Information

Owner: Co-Owner:

Address: Apartment #:

City: State: Zip

Driver's License #: State: Exp: Birthday:

Driver's License numbers are required as proof of identification, we ask for this in lieu of SNN. Please have ID available for us to verify.

Primary Phone #: Secondary Phone #:

Email:

Employers Name: Number:

Medical Records Release Consent Agreement:

In accordance with the Veterinary Practice Act regarding the confidentiality of patient medical records, a written consent is required in order for us to provide a copy of your pet's medical records. I certify that I am the owner/co-owner of the patient(s) named on the back of this form or in my account or that I am acting as a legal agent for the owner. By initialing I hereby give my consent to release my pet's medical records to fellow veterinarian practices, city/county animal control, and all others who may inquire unless specified.

_____
Initials

* If you would like to opt. out at this time and agree to have a separate consent form for future authorization please initial here.

_____
Initials to opt. out

Financial Agreement:

I, the undersigned, agree to the following terms:

1. I assume full financial responsibility for all the charges incurred for the care and treatment of this animal.
2. I understand that all payments are due in full at the time of the service, at time of pickup for surgeries, or when directed by the Doctor or Staff.
3. Hospitalized patients in need of urgent care must have a copy of a photo ID and least a 50% deposit at the time of admission, based on an estimate provided by the Veterinarian.
4. Should collection become necessary, the responsible party agrees to pay an additional 33.3% collection fee, and all legal fees of collection, with or without suit, including attorney fees and court costs.
5. If for any reason an exception is made and I am allowed to pay with a check, and it is returned for any reason, I am responsible for a Returned Check Fee of $25.

Terms of Service:

In signing below, I authorize the veterinarians and staff of Healing Hearts Animal Hospital to examine, treat, administer medications, and perform diagnostic, surgical procedures, and/or to hospitalize my pet if the doctor(s) deem it necessary for the health, safety or well-being of my pet. I agree to assume responsibility for all charges incurred in the care of my pet(s), as well as reasonable attorney's fees, court costs, and interest if the balance is sent for collection.

All the information I have provided here is true to the best of my knowledge. I have read and understand the Medical Records Release Consent Agreement, Financial Agreement, and Terms of Service and agree with the above information.

Signature: Date:

Pet's Information

Pet's Name: _____

Pet's Breed: _____

Pet's Color: _____

Please Circle: Male or Female Spayed/Neutered

Pet's Birthday: _____ Pet's Age: _____

Additional Pet

Pet's Name: _____

Pet's Breed: _____

Pet's Color: _____

Please Circle: Male or Female Spayed/Neutered

Pet's Birthday: _____ Pet's Age: _____

Additional Pet

Pet's Name: _____

Pet's Breed: _____

Pet's Color: _____

Please Circle: Male or Female Spayed/Neutered

Pet's Birthday: _____ Pet's Age: _____