Welcome to Locust Trace Veterinary Clinic

Date:_____ Driver's License Number (required):_____ DOB_____

Name: LAST:_____ FIRST:_____ Co-Owner_____

Email

_____

Mailing Address_____City/State/Zip

Physical Address (if different from above):

_____

Mobile Phone:_____ Home

Phone:_____

Employer:_____Work Phone:_____

Emergency Contact (other than self)_____

Phone:_____

How did you learn about us? (Check all that apply) Google____ Social Media____ Friend/ Family/

Neighbor_____ If a friend/family/neighbor referred you, please tell us who they are!

_____

*****ALL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED*****

Client Agreement: I understand that Locust Trace Veterinary Clinic utilizes the services provided by Madison County Attorney for returned checks and all accounts sent to the county attorney are subject to additional fees and penalties. I also understand that any balance that remains unpaid for any reason will be sent to a professional collection agency and I agree that I will be responsible for additional fees and penalties incurred to Locust Trace Veterinary Clinic for collections on this account, as well as interest accrued at 1.5% monthly. Locust Trace Veterinary Clinic reserves the right to present past due accounts to a small claims court in place of a collection service.

I have read the statements above and understand the hospital payment policy. I acknowledge that I am the responsible owner of the pet(s), or authorized agent of the owner, associated with the below named pet(s) and represent all other owners. I assume responsibility for all charges incurred in the care of the animal. You must be 18 years or older to legally sign this consent.

Signature of client responsible for pet(s)_____
Date_____