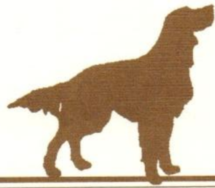

Dr. Lashley's

SMALL ANIMAL HOSPITAL, LTD.

3120 North Illinois Street • Swansea, Illinois 62226
Phone (618) 234-4584 • Fax (618) 234-4528

INITIAL CLIENT INTERVIEW FORM

OWNER INFORMATION

First Name: ______________________ Last Name: ____________________________________

DOB: ______________________ Driver's License:_______________________________ _____
Issuing state, number, and expiration

Spouse First Name: ____________________ Last Name: ____________________________________

DOB: ______________________ Driver's License:____________________________________
Issuing state, number, and expiration

Address: ____
Street City State Zip

Home Phone: _________________ Cell Phone: __________________ Email:________________ ______________

Employment: ____
Name Address Telephone

Spouse Employment: ____
Name Address Telephone

Have you been here before? _ Yes _ No Previous Veterinarian: _______________________________

PET INFORMATION

Pet's Name: ____________________ Breed: __________________ Age: _____Birth date: __________

Species: ___ Canine ___ Feline ___ Other____________ Sex: ___ Female ___ Male Color: ____________

Spayed/Neutered: __________ Known Allergies? ____

Chronic Health Conditions? y/n (If yes, please describe) ____

Is your pet on any medications, pain killers (including aspirin), supplements, or special diet? _ Yes _ No

Please specify, including dosages and frequency: ____

Pet's Name: ____________________ Breed: __________________ Age: _____Birth date: __________

Species: ___ Canine ___ Feline ___ Other____________ Sex: ___ Female ___ Male Color: ____________

Spayed/Neutered: __________ Known Allergies? ____

Chronic Health Conditions? (please describe) ____

Is your pet on any medications, pain killers (including aspirin), supplements, or special diet? _ Yes _ No

Please specify, including dosages and frequency: _______________________________________

GENERAL INFORMATION

How did you hear about us? ____ Veterinarian Referral ___ Website ___ Yellow Pages ___ Friend
___ Street Sign ___ Advertisement: _______________ Other ________________________
Specify
Preferred Method of Payment (Please check one): ___ Credit Card ___ Check* ___ Cash

LEASH POLICY

For the protection of our clients and their pets, and in accordance with State and Local Regulations, we require that all clients keep their pets on a leash or in a cage while on the premises.

FINANCIAL POLICY

Payment is due as services are rendered. For hospitalized cases, a deposit is required in advance. The balance is due upon discharge from the hospital. Payment by cash, personal check, or Visa/MasterCard/Discover credit cards is accepted. In addition to the amount of the check, a minimum sum of $25.00 will be charged for dishonored checks.

We reserve the right to collect any unpaid balance due to this office. All statements for services rendered and costs and/or services rendered on behalf of the Client which are delinquent more than thirty (30) days are subject to an eighteen percent (18%) per annum interest charge. If a client is not making regular payments on the account balance, we may use a collection agency or take legal action to secure payment, as authorized by state or federal law. Clients will be notified in writing before an account is referred for collections.

CANCELLATION POLICY

When you schedule an appointment with our office the time is reserved for you. There is no fee if you cancel an appointment more than 24 hours in advance of the appointment. **If you cancel or do not keep an appointment without giving twenty-four hours' advance notice, you will be charged a fee for the time you had reserved unless you meet one of the following exceptions:** 1). If you are ill and do call before the appointment time to cancel your appointment, there will be no charge. 2). If you reschedule and keep an appointment that occurs within seven days of the missed appointment you will not be charged for the missed appointment.. 3.) One missed appointment fee per year will be forgiven. **All missed appointments that do not meet the exceptions above will be charged the fee of $60.00.**

AGREEMENT

I am the owner or the agent of the owner, of the above-described pet(s) and have the authority to execute this agreement. I authorize Dr. Lashley's Small Animal Hospital, Ltd., its agents, servants, and/or employees to examine and treat the above-named pet(s), to administer such treatment as is necessary, and to perform such additional procedures as are considered therapeutically and/or diagnostically necessary on the basis of findings during the course of any evaluations made by this facility. I also consent to the administration of such anesthetics as are necessary, and certify that no guarantee or assurance has been made as to the results that may be obtained.

I accept full financial responsibility for the treatment provided. In the event that I fail to pay for services rendered, I hereby agree to pay the reasonable attorneys' fees and costs incurred by Dr. Lashley's Small Animal Hospital, Ltd. to collect any amounts owed.

I have read this agreement, fully understand the terms and provisions contained herein, and agree to comply with all of its provisions.

Owner(s) Signature: ________________________________ Date: _________