

ADMIT DATE: _____ ADMIT TIME: _____

CLIENT INFORMATION

Home Telephone (____) _____ E-Mail _____
 Cell Telephone (____) _____

Owner's Name _____ Spouse/Other _____
(Person responsible for financial obligations)

Address _____ City _____ State _____ Zip _____

Employer _____ Employer Telephone # _____

Emergency Contact Person and Local Telephone # _____

How did you first hear of our service?

Hospital Sign Yellow Pages Prior Client Internet Other _____

Please indicate if you would allow photographs of your pet to be placed on our website and/or printed material Yes No

For NON-AAH Clients here on an Emergency.....

Pet's family Veterinarian and Hospital is _____
(This is where we will send a report of your pet's diagnosis and treatment)

Were you told about our Service by your family Veterinarian? Yes No

Or is this a **Direct Referral for an ongoing critical care case?** Yes

PATIENT INFORMATION

Pet's Name _____ Sex – Male / Female / Unsure Neutered/Spayed – Y / N

Canine (Dog) Feline (Cat) Avian (Bird) Reptile (Snake/Lizard) Rabbit Ferret Other _____

Breed _____ Coloring _____ Date of Birth _____
(Approximate Age)

Date of Last Vaccinations

Canine	Distemper/Parvo _____	Rabies _____	Heartworm _____
Feline	Distemper/Resp _____	Rabies _____	Leukemia _____
Other	_____		

Diet (What pet is regularly fed) and Time of Last Feeding _____

Other Pets in the House _____

Any known medical problems (seizures, diabetes, heart problems, etc.) _____

PET'S PRESENTING PROBLEM

Alexandria Animal Hospital and Veterinary Emergency Service is dependant upon your payment of fees to maintain our high quality of patient care. The Hospital does not extend credit (bill) and you are responsible for all fees for products and services rendered. **There is an Urgent Examination fee of \$110 for pets without an appointment.** We will provide a TREATMENT PLAN and associated fees prior to starting any treatment following the initial examination and diagnostics performed. A deposit will be required prior to initiating treatment.

AUTHORIZATION for EXAMINATION, TREATMENT and ASSUMPTION of FINANCIAL RESPONSIBILITY

I, the undersigned, authorize the veterinarian(s) and their staff to examine the patient specifically described and identified above and to administer any medical, surgical treatments and/or tests, including sedation or anesthesia which is considered necessary based on findings during the course of examinations.

I assume responsibility for all charges incurred for services rendered to the patient. I understand there is a \$25 service charge for returned checks and that unpaid accounts may accrue a \$15 late fee after thirty (30) days, plus interest at the rate of 1.5% per month (18% per annum) compounded monthly. If collection action is necessary on this account, I agree to pay all costs of collection, plus attorney fees of 33% of the balance owed, whether or not suit is filed. The parties agree to the exclusive venue and jurisdiction of the City of Alexandria, Virginia, for all matters arising from this agreement.

PAYMENT: I agree to pay, in full, any remaining balance for services rendered when my pet is discharged from the Hospital.

Signature of Owner or Responsible Agent (18 years or older)

Witness (AAH/AVES Employee)