NEW HOPE
ANIMAL HOSPITAL

New Client Information

Client Name:	
Co-Owner:	
Mailing Address:	
City, State, Zip:	
**** Email:**	

Primary Phone Number:		**Location:**
Secondary Phone Number:		**Location:**

**** Previous Veterinarian/Veterinary Clinic?**
**** How did you hear about us?**
**** Would you prefer to receive reminders by ☐ Email or ☐ Mail?**
Pet Name
Breed/Color
Sex
Age

Professional Fees Are Due At The Time Services Are Rendered

I request that New Hope Animal Hospital's doctors and staff perform the services which are necessary to the examination and medical treatment of the animal(s) presented by me. I am the owner or agent for the owner of the described animal(s) and have authority to execute this consent. Provider is hereinafter understood to mean New Hope Animal Hospital, its veterinarians, agents and employees.

I authorize the veterinarians on duty (and assistants they may designate) to examine the animal(s) and to administer medical treatment or emergency care which is considered therapeutically and/or diagnostically necessary on the basis of the examination findings. I, therefore, hereby consent to and authorize the

performance of such procedures as deemed necessary and desirable in the veterinarian's professional judgment.

I understand that the treatment of the patient(s) will be conducted with due care and in accordance with the prevailing standards of care in veterinary medicine. I certify that no guarantee or assurance has been made as to the results that may be obtained through the course of treatment undertaken by the Provider. Accounts over 30 days past due shall pay interest at the maximum legal rate. I agree to pay all attorney's fees, interest, collection costs and other costs of litigation incurred in the collection of past due accounts. The provider shall not be responsible for the loss, theft or destruction of any personal property left with my pet(s).
I understand that an estimate may be provided at my request. I also consent to the release of medical information to other authorized veterinary and/or boarding facilities.
I assume financial responsibility for all charges incurred to the patient for services rendered and understand that full payment is required upon discharge.
I authorize any person with possession of the described animal(s) in addition to myself to request veterinary care for the described animal(s) and have the authorization to make medical decisions for the described animal(s) in my absence. In addition, I understand all services/products rendered by that person will be my financial responsibility.

_____

Signature of Responsible Agent

Staff: Please Complete This Section

____Previous Veterinarian Called. Records Requested.
____Records Received
____Reminders Set Up

Scan in completed client portion at time of visit. Keep in folder at front desk until all three steps have been fulfilled.