CLIENT ID #: _____ **DATE:** _____ **UP-DATED IN COMPUTER DATE:** _____ **STAFF ID:**_____

For Office Use Only

Charlottesville Cat Care Clinic

1901 Seminole Trail, Charlottesville, VA 22901

434-975-CATS (2287) Fax: 434-973-7640

Thank you for giving our hospital the opportunity to care for your cat. So that we may become better acquainted, please complete the following: (PLEASE PRINT LEGIBLY)

PLEASE FILL OUT EACH SECTION COMPLETELY

Tell us about you! **Have any of your cats ever been a patient here?: [ ] Yes [ ] No**

Your Name _____ Date of Birth _____

Street Address _____

City _____ State _____ Zip _____

Mailing Address (if different than above) _____

Home Phone _____ Cell Phone _____

Business Phone _____ext _____ Other Phone _____

Place of Employment _____ Department _____

Your E-mail Address _____

Can we send you e-mail or text reminders for your cat's appointments, vaccine due dates, etc.?
Yes [ ] No [ ]

Spouse / significant other / person sharing responsibility for your cat?

Name _____ Relationship _____
(Spouse, Co-owner of Cat, etc.)

Address (if different than above) _____

City _____ State _____ Zip _____

Home Phone _____ Business Phone _____ ext _____

Cell Phone _____ Place of Employment _____

Spouse/ significant other's E-mail Address _____

How did you hear about us?

[ ] Hospital Sign [ ] Yellow Pages Book [ ] Humane Society [ ] Another Veterinary Practice
[ ] Website(s), Please specify which one(s)_____(Yelp, Facebook, etc.)
[ ] Personal Recommendation [ ]Other _____
Name of person or hospital that referred you to us _____

Payment Policy

FULL PAYMENT IS EXPECTED UPON RENDERING SERVICE. Deposits may be required on major medical/surgical cases, trauma cases and emergency work where hospitalization is required. **We DO NOT carry open accounts** and hope these alternatives are convenient to you:

PLEASE circle PRIMARY payment method: CASH CHECK VISA MC DISCOVER

IF admitting my cat, I authorize Charlottesville Cat Care Clinic and its staff to administer vaccinations, medications, anesthetics, surgical procedures, tests, and necessary treatments that Dr. Mahanes and her associates find appropriate for the health, safety, and comfort of my cat while in their care. I understand that if my cat is found to have internal or external parasites (fleas, mites, worms, etc.), he/she will be treated at my expense. If any treatments not previously discussed with the owner are found to be necessary, all attempts will be made to contact the owner before they are administered. Missed or cancelled appointments, without 24 hours prior notification, are subject to a Missed Appointment Fee. In case of non-payment, a finance charge of 2 % monthly (24% annually) with a $5 minimum, and any collection and/or attorney fees will be paid by me.

A $50 charge will be assessed for all returned checks. If payment will be made by check, ***PLEASE*** provide your Driver's License Number here _____.
You may also be asked to provide identification if payment is made by check.

I have read and understand the above authorization _____ Date _____

Signature of owner or authorized representative

I understand that this form will be a permanent part of my cat's record