hillside
VETERINARY HOSPITAL

Client Information

Date: _____

Name: _____
First Middle Initial Last

Address: _____
Street City, State, Zip Code

Primary Phone #_____Type: _____ Secondary Phone #_____Type:_____

Email address _____

Alternate Contact: _____
Name Phone Relationship

- In admitting my pet(s) for diagnostics, treatment, or surgery, I authorize the veterinarians of Hillside Veterinary Hospital, and their support staff, to administer such treatment and/or perform such diagnostic or surgical procedures as deemed necessary.
- I understand that I assume full financial responsibility for all charges incurred by my pet.
- I realize that these charges may exceed a given estimate if complications arise. I understand that I will be contacted prior to treatment, if possible, should complications occur.
- As our client, you agree to pay for any collection or legal costs incurred in the collection of any debt. In order to reinstate your
- account all balances will need to be paid in full.

PROFESSIONAL FEES ARE TO BE PAID AT THE TIME SERVICES ARE PERFORMED

Signature: _____