Employee Initials _____________ Client ID# _____________

Cottonwood Veterinary Hospital

Small Animal and Equine

CLIENT INFORMATION FORM

Your Name: Last_________________________ **First**_____________________ **Title**_________

Spouse/Co-Owner: Last_____________________ **First**_____________________ **Title**_________

Street Address_________________________________ **Zip Code**_________

City_____________________ **State**________ **County**_________________

Physical Address (if differs from above) _________________________________

Home/Cell Phone_______________ **Work Phone**_____________ **Alternate Cell Phone**______________

E-mail____

Social Security Number______________ **Drivers License**_________________ **Issuing State**______

Employer_________________________

Preferred Doctor? (Circle option if applies): Dr. Tom Jakob Dr. Jessica Kirkpatrick Dr. Jennifer Billman

Referral (Who may we thank?) _______________**or Other**____________ **(i.e.** ***Location, Hospital Sign, Yellow Pages, Promotion, Emergency Clinic, Website/Facebook, Internet*****)**

Is your pet(s) allowed to be part of our Social Media (*Circle One*)? ***Yes No***

Do you have a preferred way to receive vaccination reminders (*Circle One*)? ***Email Text Mail No Preference***

*****DOCTORS WILL STILL EMAIL YOU WITH CLIENT UPDATES AND QUESTIONS.*****

Pet's Name	Species	Breed	Color	Birthday/ Approx Age	Sex (Neutered/Spayed?)	Microchip #

Previous Veterinary Hospital _________________________ **Phone Number**______________

What brand of food do you feed your pet(s)?_____________________

FINANCIAL INFORMATION

I hereby authorize Cottonwood Veterinary Hospital to provide treatment for the above described animal(s) and understand that I am financially responsible to Cottonwood Veterinary Hospital for all charges incurred during or as a result of my pet's visit. I agree to pay all charges promptly upon presentation thereof unless prior credit arrangements have been agreed upon in writing.

I agree to pay all service charges, collection, legal and court fees in the event it becomes necessary to pursue my account for collection. I have read, understand and agree to all terms of the Care and Payment Policy on the reverse of this form. I am entitled to a copy of this agreement at the time I execute said agreement and hereby acknowledge receipt of this form. I give my permission to Cottonwood Veterinary Hospital to release vaccination information to other veterinarians, city or county officials, kennels or groomers.

Client Signature ____ Date ______________

Cottonwood Veterinary Hospital

Thomas Jakob, DVM Jennifer Billman, DVM Jessica Kirkpatrick, DVM
450 Cottonwood Road, Bozeman, MT 59718
Phone: (406) 582-0555
Fax: (406) 582-4496

Release of Medical Records and/or Radiographs:

Due to new rules established by the Montana Board of Veterinary Medicine, Cottonwood Veterinary Hospital **cannot** provide vaccination or medical information **verbally or electronically** to kenneling, grooming, or other veterinary facilities. Signature approval is needed for verifying and for legal requirements set by the state of Montana.

Name of pet(s) approved for future release:
____

Facilities Approved for Records Transfer:
____

I, ___________________________, the owner of the above listed animals, authorize the release of my animals' medical records and/or radiographs to the above listed parties.

CARE AND PAYMENT POLICY:

1. Payment in full is due at time of service.

2. We accept payment via cash, check, Visa, MasterCard, Discover and American Express. Sorry, we do not accept out-of-state checks. For all check and credit card payments we require a copy of your driver's license.

3. We offer interest free payment plans through CareCredit that allow you to begin treatment, if you qualify.

4. A deposit of 30-50% will be required for all major surgeries and/or hospitalization. The deposit is due at the time the patient is admitted. The entire balance is due at the time of discharge.

5. Emergency cases require a minimum deposit of $150 before we can begin extensive medical procedures. Emergency first aid may be initiated immediately without a deposit (if necessary, to minimize acute pain or save an animal's life).

6. A billing charge of $3.00 per month for billing and postage costs will be added to all open accounts if not paid within 30 days.

7. A finance charge of 1.50% per month (equivalent to 18% annually) will be charged to all accounts not paid in full within 30 days.

8. Additional services will not be provided or charged to accounts with outstanding balances older than 30 days.

9. There will be a $30 fee for returned checks.

10. Should your account be referred to an outside collection agency, you hereby agree to pay all collection costs, attorney fees and court costs.

Last Updated January 29TH, 2020