East Maiden Animal Clinic
498 East Maiden Street
Washington, PA 15301
724-225-2312

Client Information

Welcome to our clinic. Thank you for giving us the opportunity to care for your pet(s). Please help us meet your needs better by taking a moment to complete these forms in their entirety.

Name: _____ Date: _____

Driver's License Number: _____ (Required for writing checks)   Date of Birth_____

Address: _____

City: _____   State: _____   Zip code: _____

Phone number: (_____) _____ Cell: (_____) _____

Spouse's Name_____   Phone number: (____) _____

E-mail address: _____

In an event of an emergency, and we are unable to reach you, who else may we contact?

Name: _____ phone number: (_____) _____

*If you use us as a veterinary reference for the purpose of adoption, by signing this form, you authorize us to discuss your pet's medical history with any and all rescue/shelter organizations/ who call for verification of vaccinations and spay/neuter/ dates.

ALL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED.
We accept Cash, Checks, Visa, MasterCard, Discover and Debit cards as forms of payment.

I understand that under federal law there must be a current Doctor/Patient relationship to be prescribed any medications from the clinic.
Authorization for examination, treatment, and assumption of financial responsibility

I, the undersigned, authorize the veterinarian(s) and assistant(s) whom they designate to examine the animal(s) specifically described and identified and to administer and treatment that is considered therapeutically and/or diagnostically necessary based on the findings during the course of the exam. I understand that the treatment of the patient will be conducted with due care and in accordance with the prevailing standards of competency in Veterinary Medicine. I assume all financial responsibility for all charges incurred to the patient and understand that all fees and charges are due in full upon completion of services and that a deposit may be required for treatment. I understand that I may pay with cash, check, American Express, Visa, MasterCard, Discover, or debit card and that a $20 service fee will be charged on all checks returned. I understand that I will be responsible for all charges (legal fees, collection services, etc.) incurred by East Maiden Animal Clinic to collect any balance owed. There will be an additional 1.5% finance charge (minimum of $1.00) added per month on the balance due. A collection fee of $38.00 will be added to any balance that is sent to our collection service.

Signature_____ **Date**_____