

18840 Soledad Cyn. Rd.
Canyon Country, CA 91351



661-424-9900
fax: 661-424-9409

Client Name: _____ DL# _____ SS# _____

Add'l Name: _____ DL# _____ SS# _____

How did you hear about us or who referred you? _____

Home Address: _____ City: _____ Zip: _____

Home #: _____ Cell #: _____ Email: _____

Employer Name: _____ Phone #: _____

Employer Address: _____ City: _____

Pet's Name	Sex Male/Female; Neutered/Spayed	DOB/Age	Species (Canine, feline)	Breed	Color

Payment Policy

Payment is due at the time services are rendered. For hospitalized cases a deposit is required in advance. The balance is due at discharge from the hospital. We accept cash, personal checks, Visa, Mastercard, American Express, Discover and Care Credit. If payment is not made at the time of service it is our policy to apply a service charge to balance over 30 days old. Service fee of \$5.00 and 1.5% of the outstanding balance will be charged to your account monthly if not paid in full.

Client Signature: _____ Date: _____

Client Consent

I, the undersigned owner, authorized agent of the owner or Good Samaritan responsible for seeking veterinary care for the pet(s) identified above, certify that I am over eighteen years of age, and hereby consent to the examination of the pet(s) by staff veterinarians at this practice. I also agree that after consultation with me, the hospital's doctors may prescribe medication for, treat, hospitalize, sedate, anesthetize and/or perform surgery on this animal. I understand that some risks always exist with anesthesia and/or surgery and that I am encouraged to discuss any concerns I have about those risks with the attending veterinarian before the procedure is initiated.

Should some unexpected life-saving emergency care be required and the attending veterinarian be unable to reach me, this practice's staff DOES _____ / DOES NOT _____ have my permission to provide such treatment and I agree to pay for all related fees.

Client Signature: _____ Date: _____

In case of an emergency, if I cannot be reached please contact:

Name: _____ Phone: _____

**Ask about our
REFERRAL PROGRAM!**



**Ask about our
PREVENTATIVE
CARE PACKAGES!**