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# CLIENT APPLICATION

## Welcome to our Hospital!

We look forward to serving you and your pets. We'll be happy to answer any questions you have about your pet's health. To insure the best care possible, please take the time to fill in this form completely.



*Our goal, as always, is to help your "best friend" live a long, happy and healthy life.*

### OWNER INFORMATION

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_  
 Date of Birth \_\_\_/\_\_\_/\_\_\_ SSN \_\_\_-\_\_\_-\_\_\_ Driver's License# \_\_\_\_\_ State \_\_\_\_\_  
 Mailing Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_  
 Physical Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Employer \_\_\_\_\_

### SPOUSE/SIGNIFICANT OTHER INFORMATION

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_  
 Date of Birth \_\_\_/\_\_\_/\_\_\_ SSN \_\_\_-\_\_\_-\_\_\_ Driver's License# \_\_\_\_\_ State \_\_\_\_\_  
 Mailing Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_  
 Physical Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Employer \_\_\_\_\_

If someone, other than those listed above, shares responsibility for your pet's care, please complete the following:  
Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

#### IF WE ARE UNABLE TO CONTACT YOU IN THE CASE OF AN EMERGENCY, WHO SHOULD WE CALL?

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

#### How did you find out about our clinic?

Yellow Pages  Hospital Sign  Web Site  Recommendation  Other \_\_\_\_\_

If recommended, whom may we thank? \_\_\_\_\_

Previous Veterinarian \_\_\_\_\_ Phone \_\_\_\_\_

May we contact them to get records?  Yes  No

Did you receive a copy of our Privacy Policy?  Yes  No Initials \_\_\_\_\_ Date \_\_\_\_\_

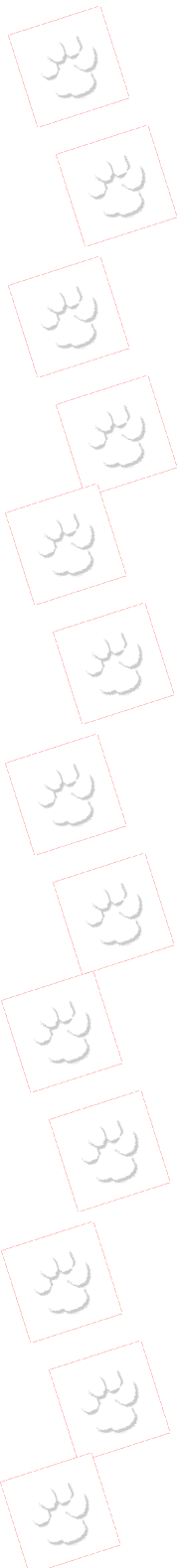
We are happy to provide an estimate before treatment begins. However, estimated costs are subject to change based on the needs of your pet and/or the care deemed necessary by our staff.

We reserve the right to refuse or terminate service to anyone for any reason not prohibited by law.

**ALL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED.**

For your convenience, we accept Cash, Check, Debit, Visa, MasterCard, Discover, American Express and CareCredit®\*.

\* Applying for CareCredit® only takes a few minutes and there is no fee to apply.



## PAYMENT OPTIONS

Our mission is to deliver the finest, most cost-effective health care treatment available today. We want to ensure that you are getting the best value and strive to set our fees accordingly. Following your pet's diagnosis, your veterinarian will advise you of the plan for treatment and provide you with an estimate for the cost of services. Feel free to discuss fees before services are performed.

***Prior to treatment, a deposit may be required.***

**ALL ACCOUNTS ARE TO BE PAID IN FULL AT THE TIME OF TREATMENT.**

We are sensitive to the fact that some pet owners may not be able to pay cash for their pet's treatments; therefore, we offer several alternatives for your convenience:

- \* **CASH**
- \* **CHECKS:** Local checks written for the full amount due, with the date of service, file name as well as check writer's name and signature, valid ID and phone number.
- \* **CREDIT CARDS:** Debit/VISA/MasterCard/Discover/American Express
- \* **CARECREDIT®:** This is a separate line of credit which does not affect the balances of your other credit cards. Unlike other credit cards, there are no annual fees. Promotional 12-Month Same As Cash and Extended Payment Plans are also available under the CareCredit® Plan. Ask our front office staff for an application form.

I understand every effort will be made to achieve a successful outcome and to provide for all possible safety in hospital care and handling. I hereby authorize this hospital to receive, prescribe for, treat or perform surgery upon the pet(s) I have presented. Furthermore, I agree to pay all fees for services rendered at the time the pet is discharged from the hospital or the service is otherwise terminated. I agree to pay for the reasonable costs of collection in the event that collection efforts become necessary. I understand that a service fee of \$30.00 will be assessed for each non-sufficient fund check. All accounts unpaid after 30 days receive a \$4.75 Billing Charge each month and a late charge computed at a periodic rate of 0.875% per month and an annual percentage rate of 10.5%, allowable per Alaska statutes. Accounts turned over to collections will be charged 40% in addition to the charges accumulated. I understand that veterinary service is provided during nighttime hours as necessary in the judgment of the veterinarian in charge. Continuous presence of qualified personnel may not be provided. If I neglect to pick up my pet within five days of the discharge date and do not notify you within that time period, you may assume that the pet is abandoned and are hereby authorized to dispose of the pet as you deem best and/or necessary.

Client Signature \_\_\_\_\_ Date \_\_\_\_\_

MMAH Representative \_\_\_\_\_ Date \_\_\_\_\_

**For Hospital Use Only – Information Verified With Client:**

Date _____ Initials _____	Date _____ Initials _____	Date _____ Initials _____	Date _____ Initials _____	Date _____ Initials _____
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