ACCOUNT NUMBER

SHENANDOAH ANIMAL HOSPITAL, INC.

Name _____

Spouse/Significant Other _____

Address_____

_____

Phone (Home) _____ Cell Phone _____

Email for reminders _____

Place of Employment _____

Work Phone _____

Emergency Contact _____Phone_____

Additional Comments

_____

_____

_____

_____

_____

_____

PAYMENT POLICY

All fees must be paid in full at the time services are performed or upon discharge from the hospital. Any exception to this policy must be authorized PRIOR to the performance of any service. We accept (cash, checks, Master Card. Visa and Discover) for your convenience. There is a finance charged of 1.5% per month (18% APR) minimum $1 a month with the addition of any or all collection agency and or all attorney fees necessary to collect the full amount due to Shenandoah Animal Hospital on balances over 30 days.

Client Signature _____

Date _____