



DANCING CATS FELINE HEALTH CENTER

Welcome to our Practice!

Client Information:

Date: _____

Last Name: _____

First Name: _____

Mailing Address: _____

City: _____ Zip: _____

Physical Address: _____

City: _____ Zip: _____

Home Phone: (____) _____ - _____

Work Phone: (____) _____ - _____

Cell Phone: (____) _____ - _____

Alternate Phone: (____) _____ - _____

Spouse/Partner's Last Name: _____

Spouse/Partner's First Name: _____

Emergency Contact Name: _____

Phone: (____) _____ - _____

Current Employer: _____

Phone: (____) _____ - _____

Employer's Address: _____

City: _____ St: ____ Zip: _____

How did you learn about our practice? _____

Please let us know if any of your information changes!

I understand that I am financially responsible for all charges incurred by me on behalf of my pet at Dancing Cats Feline Health Center (DCFHC). I agree to pay for all services at the time they are rendered and my pet is released to me. If charges are covered by an insurance company, I will pay DCFHC directly and take responsibility upon myself for recovering said charges from the insurance company. I understand that if I fail to pay for services as agreed herein, legal action could be taken against me. I understand that if this account is assigned to an outside agency for collection, I agree to pay all attorney fees, with or without suit, court costs and a collection agency fee of 40% which will be added to the outstanding balance of my account. I agree to pay interest to DCFHC at the rate of 1.5% per month (18% per year). I agree to pay a service fee of \$30 for any returned/bounced check. I authorize DCFHC to release all information necessary to secure payment. Any balance unpaid for 90 days may be turned over to collections.

Signed: _____

Client