

**CLARKE COUNTY ANIMAL HOSPITAL**  
**DR. C. ED SELLERS**

Name \_\_\_\_\_ Married \_\_\_\_\_ Single \_\_\_\_\_ Minor \_\_\_\_\_  
                     Last                      First                      Middle

Address \_\_\_\_\_  
 Street Apt. City State Zip

Birthdate \_\_\_\_\_ Telephone \_\_\_\_\_ E-mail \_\_\_\_\_  
 Month Day Year Home# Cell#

Place of Employment		
	Name	Address Phone #

SSN \_\_\_\_\_ Driver's Lic. # \_\_\_\_\_

Spouse's Information:				Patient Information:		
Last	First	Middle		Name	Species	Breed
Street	City	State	Zip	D.O.B.	Sex	Color
Cell #	D.O.B.	Driver's Lic. #		Spayed/Neutered	Date of last vaccines	
Employer Name		Address		Heartworm Prevention	Other Meds.	
Employer Phone #		SSN		Other Pets		

**To help prevent the spread of infectious diseases, ALL hospitalized and boarded animals must be current on all vaccinations. DUE TO STATE LAW AND INSURANCE REQUIREMENTS, ALL DOGS & CATS MUST BE CURRENT ON RABIES VACCINATION. Vaccinations can be updated at the time of appointment if it is not current. All animals are also required to be on a leash or in a cage for their safety and the safety of our other patients.**

**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) listed. If I neglect to pick up my pet within 5 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 necessary. Payment in full, by cash, check or credit card, is expected when treatment is performed or animal is discharged. In case of any emergency hospitalization, payment arrangements must be made with the receptionist. On your request we will provide you with a written request of fees before care is provided. Patients can not be released from CCAH until payment is made in full. There will also be a \$35 fee for all returned checks.**

**I understand that if I do not pay the entire balance within 25 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.5% per month (or a minimum charge of \$3.00) which is an annual percentage rate of 18% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.**

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**How do you wish to pay for your visit today: CASH\_\_\_ CHECK\_\_\_ CREDIT CARD\_\_\_**