Academy ANIMAL CARE

3372 Pruden Blvd, Suffolk, VA 23434
Phone: (757) 934-2272 | Fax: (757) 539-6512
recep1@AcademyAnimalCare.com
AcademyAnimalCare.com

NEW CLIENT REGISTRATION

PET INFORMATION

Name: _____ **Species:** ☐ Dog ☐ Cat ☐ Other: _____

Sex: ☐ Male ☐ Neutered ☐ Female ☐ Spayed **Breed:** _____ **Color:** _____

Age or DOB: _____ **Previous or Referring Veterinarian:** _____

Does your pet have any allergies or pre-existing conditions? _____

_____

In the event your pet becomes lost, may we release your name, address, and phone number to the finder? ☐ Yes ☐ No

OWNER INFORMATION

First Name: _____ **Last Name:** _____

DOB: _____ **Street Address:** _____

City: _____ **State:** _____ **Country:** _____ **Zip Code:** _____

Home Phone: _____ **Cell Phone:** _____

Email Address: _____

Spouse/Alt Contact: _____ **Relation:** _____ **Phone:** _____

HOW DID YOU HEAR ABOUT US?

☐ Friend/Family ☐ Location ☐ Google/Yahoo Search ☐ GPS ☐ Radio ☐ Referring Veterinarian ☐ Other _____

AUTHORIZATION

I give permission for photos and videos of my pet to be used in all forms of social media, including Facebook, YouTube and Twitter. ☐ YES ☐ NO

PAYMENT IS DUE WHEN SERVICES ARE RENDERED.
We accept cash, American Express, Visa, MasterCard, Discover, and CareCredit.

I certify that I am the person responsible for authorizing and paying for all medical procedures and expenses for the listed pet(s).

Owner Signature: _____ **Date:** _____

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RELEASE FORM

I, the undersigned owner or authorized agent of the animal named _____, do hereby authorize Dog Doc Corp., P.C., t/a Academy Animal Care, Dr. Glenn Chase (the "Practice"), and its veterinarians and staff, to administer such treatments and to perform such procedures as are considered therapeutically and/or diagnostically helpful or necessary for the care of my animal, including the administration of anesthesia.

In the event that emergency treatment is required and I cannot be reached, I authorize the Practice and its veterinarians and staff to perform such medical and surgical treatment as is necessary to preserve the life of the patient until I can be contacted for further authorization. I understand that no guarantee of successful treatment is made.

I ACCEPT FINANCIAL RESPONSIBILITY FOR THE TREATMENT OF THE ABOVE-NAMED PATIENT AND UNDERSTAND THAT PAYMENT IN FULL IS DUE UPON RELEASE OF THIS ANIMAL FROM THE HOSPITAL OR WHEN SERVICE IS OTHERWISE TERMINATED. I certify that I have read and fully understand this authorization for medical and/or surgical treatment, the reason why such medical and/or surgical treatment is considered helpful or necessary, as well as its advantages and possible complications, if any. I hereby release the Practice, its owners, veterinarians and staff from any and all claims for negligence, arising out of or connected with performance of his/her treatment.

In the event any bill incurred is referred to an attorney or other party for collections, I agree to pay all costs of collection, including but not limited to an attorney's fee of 33 1/3% of the balance owing at time of referral.

Owner Signature: _____ **Date:** _____

STAFFING HOURS

Business and Medical Staffing hours are as follows:

MONDAY-THURSDAY: 7:30 AM - 1:00 PM, and 2:00 PM - 6:30 PM

FRIDAY: 7:30 AM - 1:00 PM, and 2:00 PM - 5:30 PM

SATURDAY: 8:00 AM - 1:00 PM

If your pet is kept overnight, in accordance with the Virginia State Law, we must inform you that we have no one in clinic, on duty, or continuous medical staff after closing until the opening the next business day. On Sundays and holidays, the staff or doctors come in only to feed, water, exercise and administer medications.

I have read and understand the above stated staffing hours and regulations.

Owner Signature: _____ **Date:** _____

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