INDEPENDENCE ANIMAL HOSPITAL

Edward Epp, DVM Kathi Bolton, DVM
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620-331-3740

WELCOME TO OUR PRACTICE!

Thank you for giving us the opportunity to care for your pet. Please complete the following information so that we may more efficiently support you and your pet. **PLEASE PRINT**.

CLIENT INFORMATION (person responsible for the account):

Name _____ Spouse's name _____

Address _____ City/State _____ Zip _____

Phone _____ Work phone _____ Cell phone _____

Spouse work phone _____ E-mail address _____

(E-mail addresses will be used only for communication sanctioned by our clinic)

Place of employment _____ Best time to reach you_____

Driver's License #_____ Date of Birth _____

ALL PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED. Payment may be made by cash, check, debit card, Master Card, VISA, Discover, or Care Credit.

The signature below authorizes preventive care regarding vaccinations and parasites and agrees that appropriate charges will be assessed in the discharge invoice. The signature below also confirms the client's agreement to pay at the time of service for all services rendered. In cases of extensive medical or surgical procedures, when full payment may be difficult, the client agrees to a payment plan as approved by the hospital business manager.

Signature of Responsible Agent for Pet(s) _____ Date_____

Will you be paying by: ___ Cash ___ Check ___Credit/DebitCard ___CareCredit ___Pet Insurance

How did you select us?

____ Yellow Pages ☐ ____ Location/Sign ____ DVM refer ____ Facebook ____ Website

____ Internet ____ Referral – if referral, whom may we thank?_____

How many pets are in your household? _____