



# Harris Animal Hospital



6805 Peters Creek Rd. Roanoke, VA 24019

## Owner Information (Please Print)

Date: \_\_\_\_\_

Owner :	_____
Co-Owner:	_____
Telephone:	_____ Cell: _____ Other: _____
Address:	_____
City/State/Zip:	_____
County:	_____ (County Required for Rabies Vaccination)
Employer:	_____ Phone: _____
Email:	_____

## Pet Information #1

Name:	_____	<input type="checkbox"/> Dog	<input type="checkbox"/> Cat	<input type="checkbox"/> Avian	<input type="checkbox"/> Other	
Breed:	_____	Color:	_____			
Birthday:	_____	<input type="checkbox"/> Estimate	Sex:	<input type="checkbox"/> M	<input type="checkbox"/> F	<input type="checkbox"/> Neutered/Spayed

## Pet Information #2

Name:	_____	<input type="checkbox"/> Dog	<input type="checkbox"/> Cat	<input type="checkbox"/> Avian	<input type="checkbox"/> Other	
Breed:	_____	Color:	_____			
Birthday:	_____	<input type="checkbox"/> Estimate	Sex:	<input type="checkbox"/> M	<input type="checkbox"/> F	<input type="checkbox"/> Neutered/Spayed

### **PAYMENT IS DUE IN FULL AT THE TIME SERVICES ARE RENDERED**

I understand that if I do not pay this account as agreed, the account is subject to all costs of collection, attorney fees, and interest on any balance that is carried over a period of 30 days with a monthly finance charge of 1.5% or 18% per annum. Any check returned will be subject to a return check fee of \$35.00. I understand that the hospital staff will provide an estimate of current and anticipated charges upon my request. I am requesting that veterinary care be provided for pets presented by me or my agents. I understand that I am financially responsible for all services provided. By submitting this form I agree to the payment terms above.

**WE ACCEPT THE FOLLOWING: CASH, CHECK, MASTER CARD, VISA and DISCOVER**

Signed: \_\_\_\_\_ Date: \_\_\_\_\_