

Roseville Veterinary Clinic, PC
26 S. Greenway Avenue
PO Box 176
Boyce, Virginia 22620
540-837-1334

Client Information Form

Client Name: _____ S/O Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone# _____ Work Phone# _____

Cellular Phone# _____ S/O Phone# _____

Email: _____

Emergency Contact: _____ Phone: _____

Persons Authorized to Bring Pets in for Treatment: _____

How do you plan to pay today (Please Circle One)?

Cash Check Credit Card Care Credit

Responsible Party Authorization

In all cases, professional fees, product purchases, all costs related to treatment, testing, and boarding are the responsibility of the client, spouse, guardian, parents, or co-owner of animal(s). There will be a \$50 charge on all returned checks. Payment is expected in full at the time of services rendered. In the event that a payment plan is agreed to in advance by the hospital manager, the finance charges (no charge if paid in 30 days of billing date) are computed by a periodic rate of 1.5% per month, which is an annual percentage rate of 18%, applied to the previous balance without deducting current payments and/or credits appearing on any given bill. Upon default in the payment of any bill, the above rate will be charged on the unpaid balance at 1.5% per month until the delinquency is paid. The client or responsible party(s) further agree to pay any and all collection fees incurred, as well as legal expenses, including but not limited to collection agency costs, attorney fees, all court related costs, service and filing fees, interrogatory and garnishment fees, as well as any interest that may be adjudicated for the collection of past due debt on any and all accounts with Roseville Veterinary Clinic.

Signature_____Date_____

Print Name_____

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STAFFING DISCLOSURE FORM

Roseville Veterinary Hospital would like to notify you of our hours of operation, which are as follows:

Tuesday, Thursday, Friday: 8:00 A.M. to 5:30 P.M.

Monday and Wednesday: 8:00 A.M. to 7:00 P.M.

Please note that except during the above noted hours of operation, continuous veterinary medical care is not available.

Please acknowledge your receipt and understanding of the foregoing by signing and dating this form on the lines indicated below.

Date:_____ Signature:_____