



Client & Patient Registration Form

Date: _____

CLIENT		
Name:	Co-Owner:	
Address:		
City:	State:	Zip:
Telephone: Home () Office () Cell ()		
Other () which number is to be called 1 st ?		
Fax ()		
E-Mail:		
Copy of Driver's License		
How did you hear about us? Check all that apply		
<input type="checkbox"/> Newspaper <input type="checkbox"/> Radio <input type="checkbox"/> Internet <input type="checkbox"/> Magazine <input type="checkbox"/> RDVM <input type="checkbox"/> Friends <input type="checkbox"/> Other		
PET		
Name:		
Date of Birth:		
Sex: Spayed () Neutered ()		
Breed: Color:		
Are vaccinations up to date?		
Any known allergies?		
Any known alerts?		
REFERRING VETERINARIANS		
Name:		
Clinic:		
Address:		
City:	State:	Zip:
Telephone: Office:		
Fax:		

The undersigned acknowledges that all accounts are due and payable when services are rendered. An interest charge of 1.5% per month will be applied to any unpaid balance after thirty (30) days. In the event this account is in default, customer agrees to pay all costs of collection, including court costs and attorney fees, whether suit is filed or not. In the event that suit is filed, venue will be Clay County, Florida.

CLIENT SIGNATURE _____



Hospital Policies

All patients are seen by appointment only, and all appointments must be made with the Client Care Coordinators. Your appointments may be made over the phone or in person. **PLEASE** call if you are running late as our schedules are made to ensure that all patients receive the proper time and attention. In the event you need to change or cancel an appointment, a notice of 24 hours is appreciated.

A SEVO-Med staff member is available 24 hours a day, 7 days a week for medical emergencies. Our doctors are “on call” and will be paged for emergencies. All non-emergency calls will be returned by the end of the following business day.

Estimates for recommended procedures, diagnostic testing or suggested therapy are given to every client and is reviewed with you **before** treatment. You will be asked to sign our copy and a copy will be given to you for your records. Changes may need to be made to your pets treatment or hospitalization plan. If the amount exceeds 25% we will revise your estimate and again ask that you approve before we proceed.

At the end of your appointment, you will be given a discharge summary explaining the doctor’s findings, results and individualized recommendations for treatment and care for your pet as well as medications dispensed or recommended. Your regular veterinarian will receive a fax or email of your summary within 24 hours.

If you need medication refills before your next visit, please allow 24 hours. Some medications may be shipped to your home for a postage fee.

By signing, you understand and agree to the above policies

Client Signature

Date



Media Release Form

I hereby **AGREE** / **DO NOT AGREE** to allow my pet, _____, to be photographed and/or videotaped for use in SEVO-Med photographs, videos, publications, internet, news, social media sites and web pages for special projects or publicity.

Signature: _____ **Date:** _____



Oncology

Dr. Tracy LaDue, *DACVIM, DACVR*
Dr. Jennifer Locke, *DACVIM*
Dr. Zachary Neumann, *DACVIM*

Internal Medicine

Dr. Katrina Toshach, *DACVIM*
Dr. Abigail Bertalan, *DACVIM*

Date: _____

Client name: _____

Pet's name: _____

This agreement between Southeast Veterinary Oncology and Internal Medicine for the transportation of _____ (pet) a canine/feline and the pet owner _____ (name) _____ (complete address).

By signing below, you authorize and agree to hold Southeast Veterinary Oncology and Internal Medicine harmless for any damages to _____ (pet), while he/she is being transported to/from their facility for overnight care.

Owner _____ Date _____
Agent _____ Date _____