Owner Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouses Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spouses Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***The State of Michigan requires us to log all controlled drugs. This is the reason we ask for owner’s date***

***of birth and driver’s license number: DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DL # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

| Pet Name | Age/DOB | Sex | Cat/Dog | Breed | Color  | Spay/Neuter |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

\* Please notify your staff of any behavioral

\*\*Services are payable upon completion. ***Please be aware our practice does not accept checks.*** How would you be taking care of your bill today? \*
We accept: Visa MasterCard Discover Cash Care Credit Scratch Pay

**1) TREATMENT CONSENT:** I hereby authorize the veterinarian to examine, prescribe for or treat the above described pet(s). I assume responsibility for all charges incurred in the care of this animal. I understand that payment is always due in FULL at time of service. I recognize that financial concerns should be discussed prior to exam & treatment. The MAH staff is happy to provide estimates.\_\_\_\_\_\_\_Accept (initials)

**2)PHOTO CONSENT:** By checking below you give us permission to share your pet(s) image and story on social media. \_\_\_\_\_ Yes. I Authorize. \_\_\_No. I don’t authorize.

**3)MEDICAL RELEASE:** I hereby authorize medical records to be shared with other veterinary practices for treatment, diagnosis or transfer purposes. \_\_\_\_\_Accept (initials) \_\_\_\_Decline (Initials)

**4)CANCELATION/NO SHOW POLICY:** I accept and understand that in the event of cancelation, I will provide a 24 hour notice. If a cancellation isn’t given 24 hour notice or I don’t show to my scheduled appointment I will pay a $25.00 Cancelation/No Show Fee and will be required to pay a $25.00 deposit for future appointments.\_\_\_\_\_Accept (initials)

**5)LATE POLICY:** I accept and understand that in the event that I am 15 minutes past my appointment time there is a chance my pet will not be seen by the doctor of Mayfair Animal Hospital. If Mayfair Animal Hospital is able to see my pet I understand there may be a wait.

 **\_\_\_\_\_\_\_Accept (initials)**

Signature of Owner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_