Patient Intake Form

Cornerstone Veterinary Services
8231 N. Hwy, Rock Spring, GA 30739
(706) 375-7314

OWNER INFORMATION

First Name:	Last Name:	Additional Owner(s):
Address (Street, City, Zip):		
Phone (Home):	Cell:	Work:
Driver's License #: OR Social Security #:		
Employer:		

PET INFORMATION

Pet's Name:		Species: ☐ Canine ☐ Feline Other:
Breed:	Age:	Sex (Please circle one): Male Male Neutered Female Female Spayed

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TREATMENT AUTHORIZATION

I hereby authorize Cornerstone Vet to perform medical and initial diagnostic/surgical procedures on my pet as required for diagnosis and treatment.

I understand that I can terminate treatment at any time by contacting the doctors and assistants.

FINANCIAL POLICY

Payment is due as services are rendered. For hospitalized cases, a deposit is required in advance. The balance is due upon discharge from the hospital. You may pay by cash, personal check (with proper identification), or accepted credit cards. In order to avoid misunderstanding, please let us know *immediately* if these terms are not satisfactory.

In the event payment is not made at the time of service, it is our policy to apply a service charge to accounts with a balance over 30 days old. A service fee of $3.00 and 1.5% of the outstanding balance will be charged to your account monthly if not paid in full.

All returned checks will incur a charge of $30.00. All cost of collections will be the responsibility of the owner.

NAMES OF INDIVIDUALS AUTHORIZED TO PICK UP PATIENT FROM OUR CLINIC:
I understand that, I, (the owner or agent) is financially responsible to Cornerstone Vet for all charges relating to this patient. **I have read and agree to the treatment authorization. I have also read and accepted the financial obligations.**

Signature _____ **Date** _____