



Kindred Spirits

Animal Clinic

New Client Information

Owner's Last Name _____ First _____ Middle In. _____

Address _____

City _____ St _____ Zip _____

Home Phone _____ Cell Phone _____

Employer _____ Work phone _____

Email Address _____

Spouse (or other guardian of your pet) _____

Emergency contact _____

Emergency contact number (# other than those specified above) _____

How did you hear about us? _____

*If a client referred you to us please give us their name so that we can thank them.

Name: _____

We will make every effort to accommodate your scheduling needs. In return, we ask that you help us by keeping your scheduled appointments, and notifying us one business day in advance if you are unable to do so. Failure to comply with this policy will result in a \$10 fee.

All fees are due when services are rendered. Estimates of all procedures will be given upon request. A deposit of 50% of the total estimate is required for all hospitalized patients with the remainder due at discharge. All outstanding balances will incur a **finance charge** at the rate of 1½% per month or an **annual percentage rate** of 18% percent. Any and all collection and/or attorney fees incurred in the collection of the amount owed will be added to the outstanding balances.

Signature of Owner _____