WELCOME TO CEDAR ANIMAL MEDICAL CENTER

PO Box 550
1247 Balok Street
Gallup, NM 87305
505-722-7786, 505-863-5527 fax
Website: cedaranimalmedicalcenter.com

CLIENT INFORMATION:

Owner's Name: _____

Spouse/Other's Name: _____

Mailing Address: _____

Physical Address: _____

City, State, and Zip Code: _____

Email Address: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

Last 4 digits of Social Security #: _____ D.O.B: _____

Emergency Contact Name: _____

Emergency Contact Phone: _____

PET INFORMATION:

Pet's Name _____

Dog_____ Cat _____ Other_____

Breed: _____

Age: _____Sex: _____

Spay/Neuter: _____

Color: _____

Pet's Name: _____

Dog _____Cat_____ Other_____

Breed: _____

Age: _____ Sex: _____

Spay/Neuter: _____

Color: _____

Cedar Animal Medical Center

Office Financial Policy

Thank you for choosing Cedar Animal Medical Center as your animal healthcare provider. The following is a statement of our financial policy that we require you to read and sign prior to any treatment.

FULL PAYMENT FOR PROFESSIONAL SERVICES IS DUE AT TIME OF SERVICE. WE ACCEPT CASH, CHECK, VISA, MASTERCARD, AMERICAN EXPRESS AND DISCOVER.

We also offer **Care Credit**, which you may apply for online at our website, or we can submit your application for you. Within minutes you will know if you have been approved and can use this as a payment option immediately.

Additional Policy Information:

1. A deposit equaling **50%** of the low-end estimate is required prior to surgery and/or treatment.
2. Written estimates will be created for surgery, trauma and any cases requiring extended hospitalization.
3. Critical cases will receive stabilizing care prior to estimate and deposit. The owner will be financially responsible for stabilizing care.
4. Estimates for any additional services are available upon request.
5. We will make every effort to have estimates accurate within 20%.
6. There will be a $35.00 charge on all insufficient fund checks.
7. All delinquent accounts will be turned over to a credit reporting agency.

Our practice firmly believes that a good doctor/client relationship is based upon understanding and good communication. Thank you for understanding our Financial Policy.

I have read and agree to this Financial Policy.

_____ _____/_____/_____

Signature of Responsible Party **Date**