Southern Cross Veterinary Clinic

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PHYSICAL REHABILITATION/ACUPUNCTURE/LASER NEW CLIENT REGISTRATION FORM

ACCOUNT HOLDER'S INFORMATION

SURNAME: _____ TITLE: _____

FIRST NAMES: _____

ID NUMBER: _____

POSTAL ADDRESS: _____

RESIDENTIAL ADDRESS: _____

TELEPHONE NUMBERS: (HOME) _____ (WORK) _____
(CELL) _____ (FAX) _____
(SPOUSE) _____

E-MAIL: _____

CONTACT PERSON (Other than yourself): _____

CONTACT PERSON'S TELEPHONE NUMBER: _____

YOUR EMPLOYER: _____

PATIENT INFORMATION

NAME: _____

BREED: _____ COLOUR: _____

MALE: _____ NEUTERED: Yes / No FEMALE: _____ SPAYED: Yes / No

DATE OF BIRTH: _____

LAST VACCINATION: _____ ADULT WEIGHT: _____

MICROCHIP/TATTOO: Yes / No NUMBER _____

DO YOU FEED A VETERINARY DIET? Yes / No OR A SUPERMARKET DIET? Yes / No

PRINT NAME: _____

SIGNATURE: _____ **DATE**: _____

Please note that interest of 1.5% and/or administration fees will be charged on overdue accounts.

NO PET FOOD OR PET PRODUCTS WILL BE SOLD ON ACCOUNT.

SAVA SURCHARGE APPLICABLE ON AFTERHOUR'S CONSULTATIONS.

APPOINTMENT IS FOR:

☐ PHYSICAL REHABILITATION ☐ ACUPUNCTURE ☐ VETERINARY CHIROPRACTIC
☐ PAIN MANAGEMENT ☐ LASER ☐ PLATELET (PRP) THERAPY

REASON FOR APPOINTMENT: _____

_____

_____

_____

HISTORY/MEDICAL CONDITIONS: _____

_____

_____

_____

CURRENT TREATMENTS/MEDICATIONS (INCLUDING SUPPLEMENTS): _____

_____

_____

ANY OTHER INFORMATION: _____

_____

_____

DESCRIBE THE IDEAL RESPONSE TO TREATMENT YOU WOULD LIKE YOUR PET TO HAVE:

_____

_____

HOW DID YOU HEAR THAT WE OFFER PHYSICAL REHABILITATION/ACUPUNCTURE/VETERINARY CHIROPRACTIC/PAIN MANAGEMENT/LASER?

WEBSITE ☐ FACEBOOK ☐ WORD OF MOUTH ☐ VET REFERRAL ☐ OTHER ☐ _____

NAME OF USUAL VET: _____

NAME OF USUAL VETERINARY PRACTICE: _____

I understand and accept that primary and routine medical and surgical care (e.g. vaccinations, dentals, supply of medications) remains the responsibility of my usual veterinarian, and recognise that regular reports will be provided to my usual veterinarian to facilitate the best treatment of my pet(s).
I understand that as part of the multimodal approach to pain management, “off-label” medications may be prescribed for my pet(s).

PRINT NAME: _____

SIGNATURE: _____ **DATE**: _____

SOUTHERN CROSS VETERINARY CLINIC
CLIENT REGISTRATION AGREEMENT

GENERAL

1. I hereby certify that I am the legal owner of all the pets that are listed under my file at this facility from time to time, and that I am liable for all expenses incurred on their behalf at this facility.
2. I undertake to ensure that an adult person presents all pets for treatment, and am aware that the staff at this facility will be unable to accept instructions for treatment from anyone under 21 years of age.
3. When leaving my pets in the care of others (holiday, overseas, hospital etc) I will make provision for a responsible adult person to act on my behalf,
   3.1 Giving them express consent to contract with this facility on my behalf with respect to my pet's well being.
   3.2 Enabling them to pay deposits and other payments on my behalf.
   Should I fail to make such arrangements, I hereby unconditionally undertake to abide by the decisions made in good faith in my absence by the staff at this facility, and declare myself unconditionally responsible for the payment of all professional fees for such treatment.
4. I hereby authorize the facility to, euthanase any of my animals if they are adjudged to be suffering from a terminal or irreversible condition.
5. If I am not contactable telephonically prior to such an event, I will abide by the decision of the professional staff at this facility and indemnify them against any court action in this regard.
6. I give permission to be contacted by email, SMS and WhatsApp.
7. I grant Southern Cross Veterinary Clinic the right to take photographs and recordings of me, my pet, my minor children and my property, and to copyright, use and publish the same in print and/or electronically without my name.

PAYMENTS

8. I acknowledge that all accounts are payable in full upon presentation.
9. I am aware that payment is due on presentation of invoice at this facility, and undertake to make payment by cheques, cash, credit card or debit card/ ATM card or electronic transfer only.
10. I undertake to pay at least a deposit equal to one half of the pre-estimated account prior to discharge and accept that such deposit is an absolute pre-condition. I will settle any outstanding balance the following month.
11. I undertake to inquire as to the extent and approximate costs of a proposed treatment, failing which I unconditionally accept that I am liable for the costs thereof.
12. I hereby render myself responsible for all costs, including interest at a rate of 1.5% per month and an administration fee as determined from time to time by the facility, incurred in the recovery of the outstanding amount from time of presentation of the account.
13. In the event that an account is handed over to your Attorneys or other agent for collection, I irrevocably agree to pay for all costs on an Attorney and Client scale, Legal Counsel on their agreed scale, collection commission, (including the costs and collection commission of any correspondent Attorney employed by your Attorneys or agent in connection therewith) and interest thereon at the rate of 1.5% per month.

Signed at _____ this _____ day of _____ 20__

_____ _____
Witness

Full names: _____

ID Number: _____