31174 Cortez Blvd, Brooksville, FL 34602
(352) 631-5252

# CLIENT REGISTRATION

Client Name:_____

Address: _____Zip Code: _____

Cell Phone: (____)____-_____ Phone: (____)____-_____ Email: _____

Would you like to receive texts/emails from RRAC regarding your pet's care? ☐ YES ☐ NO

Use of your information: In general, personal information you submit to us is used to provide services, respond to requests that you make, or to aid us in serving you better. We will also use the information to contact you via email, phone call, or text for (1) phone number verification, (2) enrollment/activation activities, (3) response to your request/ inquiry, (4) encouraging or enabling your use of Services including, but not limited to, specific features, (5) billing inquiries, (6) to provide users material updates related to the services.

# PATIENT REGISTRATION

| Patient 1 Name: | Breed: | Color: |
|---|---|---|
| DOB or Age: | Sex: ☐ Male ☐ Neutered<br>☐ Female ☐ Spayed | Microchipped? ☐YES ☐ NO |
| Previous veterinary facilities where your pet has received care: | | |
| Has your pet ever shown signs of fearful or protective behavior towards animal care handlers? ☐YES ☐ NO | | |

| Patient 2 Name: | Breed: | Color: |
|---|---|---|
| DOB or Age: | Sex: ☐ Male ☐ Neutered<br>☐ Female ☐ Spayed | Microchipped? ☐YES ☐ NO |
| Previous veterinary facilities where your pet has received care: | | |
| Has your pet ever shown signs of fearful or protective behaviors towards animal care handlers? ☐YES ☐ NO | | |

**HOW DID YOU HEAR ABOUT US ?**

☐RRAC Website ☐Google Search ☐Facebook ☐Yellow Pages ☐Sign ☐ Whom may we thank for referring you? _____

☐ Other: _____

## Please initial after reading each statement carefully

____ I understand that my pet **MUST** be on a leash or in a carrier at all times while on RRAC property for safety.
____ I understand that if I need to cancel an appointment, it is requested that I do so at least 24 hours in advance.
____ I understand that it is requested that I arrive 5 minutes early for my appointments.
____ I understand that if I am more than 10 minutes late for my appointment, I may have a wait time.
____ I understand that payment is due at time of services rendered. If payment is not received at time of service, I understand that my account will incur finance charges on the unpaid balance each month. Also, if payment is not received within 90 days of services, my account may be sent to collections and will incur all charges associated with the collections process.
____ I understand that if I do not call 24 hours prior to cancel, or fail to arrive for a scheduled appointment, I may be required to prepay for future visits. A "no-show" fee may be applied to my account.
____ It is requested that I inform the reception staff of any potentially contagious conditions prior to bringing my pet in to the lobby. (This will ensure the staff has a room available for the patient right away)
____ I verify that this is my personally owned pet. This pet is not a foster pet and I am the sole/joint owner of this pet.
Additional Ower Name: _____ Cell Phone: (____)____-_____

***If this patient is a foster in your care, please list the Rescue or Organization below***

_____
Organization Name Point of Contact (If any)

_____
Organization Phone Number

# CLIENT CONSENT FOR CARE

_____ _____
Client Signature Date

The following individuals are authorized to bring my pet(s) in for medical care:

Name:_____
Phone:_____

Name:_____
Phone:_____

**If you fill out this form online please email it to us @ reception@riverridgeanimal.com, or bring it in with you. We also ask that you come in 10 minutes early to confirm/update your information.**

Thank you for visiting the River Ridge Animal Clinic!