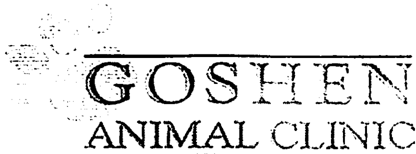

8357 Snouffer School Road
Gaithersburg MD 20879
301-977-5586 Fax: 301-9906457
www.GoshenAC.com

Client Name:______________________________________

Spouse/ Co-Owner:__________________________________

Address:____
City:____________________ State:_________ Zip Code:________

Email Address:_____________________________________

Contact Phone Number:
Primary: ____________________ home/ work/ cell
Secondary:__________________ home/ work/ cell
Other: _____________________ home/ work/ cell

How did you hear about us? ___ Google ____Yahoo ____Bing
___ sign ____yelp ___ValPak ___ Referral ____other

Financial Responsibility Agreement:

I hereby authorize and will be responsible for the exam fee of $62.00 for the Veterinarian to examine my pet. I understand that all other products and services will be in addition to the examination fee. I acknowledge that payment is expected at the time of services unless prior arrangements have been made. I further understand that if any balance is left unpaid 60 days after being incurred, I will be responsible for an additional monthly billing fee of $15.00 which will be applied to the account as well as any collection and/ or attorney fees spent in the attempt to collect this debt. I also understand that a fee of $35.00 will be placed on my account for all returned checks.

____

Print Name Signature Date

GOSHEN
ANIMAL CLINIC

8357 Snouffer School Road
Gaithersburg, MD 20879
301-977-5586 fax 301-990-6457
GoshenAC.com

Pet #1

Name: ______________________ Allergies/Alerts: ______________________

Species: __________ Breed: ________________ Sex: ________ Altered ( ) Yes ( )No

Coat Color: ________________ Birthdate: ____________ Weight: ________

Current Medical Conditions and /or Medications:

____

____

Pet #2

Name: ______________________ Allergies/Alerts: ______________________

Species: __________ Breed: ________________ Sex: ________ Altered ( ) Yes ( )No

Coat Color: ________________ Birthdate: ____________ Weight: ________

Current Medical Conditions and /or Medications:

____

____

Pet #3

Name: ______________________ Allergies/Alerts: ______________________

Species: __________ Breed: ________________ Sex: ________ Altered ( ) Yes ( )No

Coat Color: ________________ Birthdate: ____________ Weight: ________

Current Medical Conditions and /or Medications:

____

____

Name of previous vet: ______________________ phone number: ____________

Did you bring any records or have those faxed/emailed? ( ) Yes ( ) No

GOSHEN
ANIMAL CLINIC

8357 Snouffer School Road
Gaithersburg, MD 20879
301-977-5586 fax 301-990-6457
GoshenAC.com

CANCELATION POLICY Effective May 2013

Our goal at **Goshen Animal Clinic & New Market Animal Hospital** is to provide the highest quality medical care for your pet. In order to do so, we have implemented a tight appointment schedule to get all our patients seen in a timely manner. Unfortunately, our busy schedule has forced us to implement a no-show policy. The no-show policy enables us to better utilize available appointments for our patients in need of medical or injury care.

In order to be respectful of the medical needs of all patients, please be courteous and call the hospital promptly if you are unable to keep a scheduled appointment. This time will be reallocated to someone who is in urgent need of treatment.

If it is necessary to cancel your scheduled appointment, we ask that you call at least 12 hours prior to scheduled appointment. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

To cancel please call **Goshen Animal Clinic at 301-977-5586** and New Market Animal Hospital at 301-**865-3232**, if after hours please leave a message.

A no show is someone who misses an appointment without canceling prior to the appointment time. No shows inconvenience those who need medical care in a timely manner.

A failure to be present at the time of a scheduled appointment will be recorded in the patients chart as a no show. If there is a record of 2 no shows, a $35.00 fee will be billed to the account. Future services may be withheld until this fee has been paid.

A record of 3 no shows will require a deposit/payment up front for an office visit when scheduling an appointment. Thank you.

Signature: ______________________________ Date: ____________________