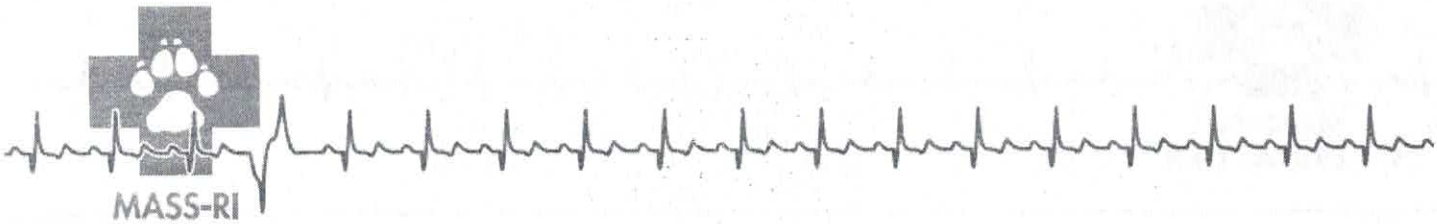

Acct# _____

Pt#_____

Owner and Patient Registration Form

Client/Owner Name: _____

Spouse/Other Responsible Party: _____

Address: _____
Street Apartment

_____
City/Town State Zip

Home Phone:_____ **Cell:**_____ **Work:** _____

Email Address: _____

Employer: _____ **Occupation:** _____

Pet's Information: _____
Name Canine or Feline Breed

_____
D.O.B. Sex M/F Neutered/Spayed Color Weight

***Date of last rabies vaccination:** _____

Primary Veterinarian:_____
Name Clinic Town

How did you hear about us?_____

List any medications your pet is currently taking: _____

Circle Method of Payment: Cash Credit/Debit Card Care Credit

Payment is required at the time services are performed. A 75% deposit is required for all animals admitted to the hospital. The balance of the bill must be paid at the time of discharge from the hospital or when services are otherwise terminated, unless other arrangements have been made. Any outstanding balance will accrue interest at a rate of 1.5% per month. If the account is referred to an attorney for collection, the responsible person(s) will pay an attorney's fee of 33.33% of this balance and all court costs incurred. If the matter is turned over to collections, I agree that Massachusetts will be the Forum state for all litigations. Should any checks be returned for non-payment, I agree to pay a bank charge of $25.00 per check.

I agree that any photos taken of my pet while at Mass-RI are the sole property of Mass-RI and can be used at their discretion.

I certify that I have read, understand, and agree to the above information. I acknowledge that my questions, if any, about the inquiries set forth above, have been answered to my satisfaction. I will not hold Mass-RI Veterinary ER, Inc. or any member or its staff, responsible for any errors or omissions that I have made in the completion of this form.

Signature: _____ **Date:**_____

Secondary Signature: _____ **Date:**_____