Sisters Veterinary Clinic LLC

Carl E. Berg DVM * Kelly Barton, DVM

Thank you for giving Sisters Veterinary Clinic an opportunity to care for your beloved pet. So that we may become better acquainted please complete the following:

Responsible Party Name/Primary Contact_____

Primary Contact #_____Home/Cell Ok to Text? Yes/No

Primary Contact Email: _____ Ok to email? Yes/No

Mailing Address (include City/State/Zip)_____

Physical Address (If Different)_____

Owner # 2: _____Relationship_____Phone#_____Ok to text? Yes/No

Emergency Contact Name_____Phone_____Ok to text? Y/N

How did you choose our clinic? *circle one* Internet Google Yellow Pages Newspaper Friend
Whom may we thank for referring you to us?_____

We accept cash, check, VISA, MasterCard, CareCredit

IT IS OUR POLICY TO PROVIDE YOU WITH AN ESTIMATE OF CHARGES FOR ANY CASES WHERE IN-HOSPITAL TREATMENT, SURGERY, OR HOSITALIZATION WILL BE PROVIDED. A DEPOSIT PRIOR TO TREATMENT WILL BE REQUIRED DEPENDING ON THE AMOUNT OF ESTIMATE. THE BALANCE AFTER DEPOSIT AND ALL OTHER SERVICES ARE DUE AND PAYABLE ON PET'S RELEASE.

Our credit and collections policy is a necessary albeit uncomfortable part of assuring the financial resources needed to maintain quality medical services to our patients. In order to establish optimal relations with our clients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial policies of this office. We request payment at the time of service.

I verify to be the owner or agent of this pet and I grant permission to Sisters Veterinary Clinic to vaccinate, treat, perform any recommended/requested, or emergency medical care to my pet. I agree to pay for services rendered when my pet is discharged to me. Any past due amounts will be subject to interest at the rate of 2% per month.

Signature_____Date_____