

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Chart #: \_\_\_\_\_

**Primary Owner Info:**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I.: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

Primary Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_ Other Contact info: \_\_\_\_\_

**Privacy Information:**

In accordance with federal, state, and local laws, Colonie Animal Hospital cannot provide services or information to persons whom the Primary Owner has not given permission for our staff to do so. In signing at the bottom of this form you are testifying you are the Primary Owner and are acknowledging that only those persons you list here may receive services on your behalf. Please note: this includes spouses, significant others, and adult children.

Additional Persons able to act on this account:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

**Financial Information:**

1. For personal checks: Driver's License#: \_\_\_\_\_ State: \_\_\_\_\_ Exp: \_\_\_\_\_
2. By signing this document below you acknowledge that Colonie Animal Hospital does not bill, take post-dated checks, or held payments for services. Payment is due at the time services are obtained by the Primary Owner or by the Additional Person(s) listed above.
3. The owner or authorized agent present for services is fully responsible at the time of service, to pay the bill.

I, the Primary owner, acknowledge my understanding to the policies and laws outlined on this form. I realize Colonie Animal Hospital has the right to change these policies as required by legal agencies.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**Pet Info:**

Name:	Dog/Cat/Other?	Breed:	D.O.B:	Sex: