Lon Randall, DVM Blythe Lyons, DVM

FINANCIAL AGREEMENT

OWNER: _____ SPOUSE: _____

Or AUTHORIZED AGENT: _____

Owner's or Agent's Social Security #: _____

Driver's License #: _____

Place of Employment: _____ Phone #: _____

Employment Address: _____ City: _____ State: _____ Zip: _____

Spouse's Place of Employment: _____ Phone #: _____

Employment Address: _____ City: _____ State: _____ Zip: _____

PAYMENT POLICY

Full payment is required upon rendering of service. Deposits may be required on hospitalized patients; an estimate will be given of the total charges for hospitalized patients, and a deposit of ½ the charges will be required.

Please indicate your choice of payment: CASH ☐ CHECK ☐ CREDIT CARD ☐

Name on check if different from owner: _____

DL # and State of Check Writer: _____

Social Security # of Check Writer: _____

Bankcard: _____ Name on card: _____

∞ We do not carry open accounts, and we hope the above alternatives are convenient for you.

∞ I have read and understand the terms of payment. I agree to pay any costs and charges necessary for the collection of any amount not paid when due. A 1.5% interest charge will be applied to all open accounts after 30 days. Should your account be referred to an agency for collection, you will be responsible for all attorney fees and/or court costs incurred.

∞ I authorize the staff of St. Francis Veterinary Hospital, Inc. to examine, initiate diagnostic tests, and administer such treatment as deemed necessary by their examination, including the administration of such anesthetics as are deemed necessary. I also certify that no guarantee or assurance has been made as to the results that may be obtained.

_____ _____

Signature of Owner or Authorized Agent Date