St. Francis
VETERINARY HOSPITAL

Financial Agreement

Owner: ________________________________ Spouse: _________________________________

Or Authorized Agent: ____

Place of Employment: __________________________________ Phone #: _________________

Employment Address: _____________________________ City: _______________ State: ______

Spouse's Place of Employment: __________________________ Phone #: __________________

Employment Address_____________________________ City: _______________ State: _______

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 charge will be required.

We accept Master Card, Visa, Discover, American Express, Cash, Check and Care Credit

Care Credit Promotional financing offered for transactions over $200 for 6 months interest free. Interest accrued will be charges in not paid in full within promotional period.

∞ 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 cost 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 test, and administer such treatment as deemed necessary by their examination, including the administration of such anesthetic 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