

# Welcome!



**Tampa Bay K-9  
Rehabilitation  
CENTER**

We're very pleased that you have chosen the Tampa Bay K-9 Rehabilitation Center for your pet's care. Please complete the following information below so that we may ensure accurate record keeping and better serve you.

Pet Owner's Name: \_\_\_\_\_ Date: \_\_\_\_\_

WOULD YOU LIKE A TOUR TODAY?  Yes  No

## New or Referred Client Information

Do you have Pet Insurance?  No  Yes (if so, which Insurance?) \_\_\_\_\_

E-mail address: \_\_\_\_\_ (We share with no one—use only for communication to you)

Spouse's or Companion's Name: \_\_\_\_\_ Driver's Lic. No.: \_\_\_\_\_

Street Address: \_\_\_\_\_ APT #: \_\_\_\_\_ Home Phone No.: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Cell Phone No.: \_\_\_\_\_

Place of Employment: \_\_\_\_\_ Work Phone No.: \_\_\_\_\_

**How did you FIRST learn about us?** (Check **one** box that tells how you FIRST heard of us)

- Veterinarian Referred Me       Verizon Yellow Page Listing       Verizon Yellow Pages Listing  
 Ad (Where?) \_\_\_\_\_       Canine Rehab-related Web Link       Drove By 1<sup>st</sup>, Saw Sign/Bldg  
 Radio/TV ad       Internet Yellow Page Search       Other: \_\_\_\_\_  
 Know Central Animal Hospital Employee (Name): \_\_\_\_\_  
 Referred by friend, relative or organization (Name): \_\_\_\_\_

**Tell us about your pet(s) ...** (Indicate below **DATE** of Last Immunizations)

DOG(s) Name(s)	Breed	Color	Age	Sex	Altered?	Distemper	Rabies	Parvo	Corona	Bordetella

**Reason your pet is here:**

- post operative (list type of surgery) \_\_\_\_\_       numbness/paralysis       pain  
 non-healing wound(s)       orthopedic problems       other \_\_\_\_\_

**How long has your pet had this problem?** \_\_\_\_\_

**What are your expectations?** \_\_\_\_\_

**Payment Information:** (Please check type of payment and sign statement below)

- Cash       MasterCard       Visa       Discover       American Express       CitiHealth Card       Care Credit

I UNDERSTAND THAT ALL FEES MUST BE PAID AT THE TIME SERVICES ARE RENDERED. I HAVE READ AND SIGNED THE FINANCIAL POLICY ON THE REVERSE SIDE OF THIS PAGE.

Client Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_

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# Financial Policy

## Central Animal Hospital & Tampa Bay K9 Rehabilitation Center

4801 Fourth Street North  
St. Petersburg, FL 33703

727.521.3518 ph  
727.527.7988 fax

**Purpose:** This is an agreement between Central Animal Hospital or Central Animal Hospital On Pinellas Point and the named person and responsible party on this form. We appreciate your choosing us for your pet health care needs, and we want to be sure you fully understand your financial obligations for the services we will be providing. By signing this agreement, you are agreeing to pay for all services rendered.

**Payment Options if you have no pet insurance:** Payment in full is due at time services are rendered.

1. You will be expected to pay by cash, VI/MC debit card or other major credit card on the day that treatment/services are rendered. We accept Master Card, Visa, American Express, and Discover. Payment by check is not accepted.
2. For extended rehabilitation, surgical or other anesthetic procedures, a minimum of **50% deposit** (cash or credit only) is due prior to the surgical or anesthetic procedure being performed. The balance is due at the time the patient is discharged.
3. For extensive treatment, you may prefer to secure third party financing (bank, credit union, etc.) for the entire amount and make payments to the lending institution.
4. We offer a special financing arrangement through Citi Health Card and Care Credit. Interest free financing for 3 or 6 months is available through CitiHealth if payment is made within the time period specified. For invoices above \$1,000.00, Care Credit financing is available.

**Payment Options if you have Pet Insurance:** We require payment in full due at the time services are rendered. We will provide you with an itemized statement to submit to your insurance company for reimbursement to you.

**Monthly Statement:** If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge and billing fees, if any, and any payments or credits applied to your account during the month. If you have a credit balance, you have the right to retain the credit balance on your account for follow up visits or request reimbursement for the credit balance.

**Finance Charge:** A finance charge will be imposed on each item of your account which has not been paid within thirty (30) days of the time the item was added to the account. The finance charge will be computed at the rate of one percent (1%) per month or an **ANNUAL FINANCE RATE** of twelve (12%) percent. The finance charge on your account is computed by applying the periodic rate (1%) to the "overdue balance" of your account. The "overdue balance" of your account is calculated by taking the balance owed thirty (30) days ago, and then subtracting any payments or credits applied to the account during that time.

**Past due Accounts:** If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collections costs which are 30% of the past due balance. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer's fees which incur plus all court costs. In case of suit, you agree the venue shall be in Pinellas County, Florida.

**Waiver of Confidentiality:** You understand if this account is submitted to an attorney or collections agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that your pet received treatment at our office may become a matter of public record.

Pet Owner's Name(s): \_\_\_\_\_ Pet Name: \_\_\_\_\_ Acct. No. \_\_\_\_\_

Responsible Party (If not the Pet Owner): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Co-Signature (If Required): \_\_\_\_\_ Date: \_\_\_\_\_



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# NEW PATIENT INFORMATION

Date: \_\_\_\_\_  
Client Name: \_\_\_\_\_  
Patient Name: \_\_\_\_\_  
Breed: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Neutered: \_\_\_\_\_  
Referring Veterinarian: \_\_\_\_\_

**Reason for Visit:** \_\_\_\_\_  
\_\_\_\_\_

Date of Injury: \_\_\_\_\_ How did Injury Occur? \_\_\_\_\_  
Has Injury Occurred Before? \_\_\_\_\_ How Often? \_\_\_\_\_  
Previous or Current Medical Issues: \_\_\_\_\_  
Current Medications (Include HW Prevention & Flea Control): \_\_\_\_\_  
\_\_\_\_\_ Supplements: \_\_\_\_\_  
Diet (What type of food) \_\_\_\_\_ How much? \_\_\_\_\_  
How often is pet fed? \_\_\_\_\_ Pet fed from a raised bowl? \_\_\_\_\_  
Fed table scraps? \_\_\_\_\_ Fed treats? \_\_\_\_\_

**Living Conditions:** \_\_\_\_\_  
\_\_\_\_\_

Are there stairs?  Yes  No  
Is your Pet Allowed on the Furniture?  Yes  No  
Where does your Pet sleep? \_\_\_\_\_  
What type of flooring is in the House? \_\_\_\_\_  
Are there any other Pets? \_\_\_\_\_  
Do you have a fenced in yard?  Yes  No  
Do you have a doggie door?  Yes  No  
Is your Pet crated during the day?  Yes  No How often? \_\_\_\_\_  
What motivates your pet?  Food  Toys  You  Praise Other: \_\_\_\_\_  
What are your Expectations of Rehab? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Work Up Performed:** \_\_\_\_\_  
\_\_\_\_\_

X-Rays: \_\_\_\_\_ Date: \_\_\_\_\_  
Bloodwork: \_\_\_\_\_  
Myelogram: \_\_\_\_\_  
Neuro-musculature Exam: \_\_\_\_\_