Welcome to Cascade Summit Animal Hospital

Owner Name: _____ Profession: _____

* Contact Info (circle primary): Cell _____ , Work _____ , Home _____

Spouse/Additional Owner Name: _____ Profession: _____

* Contact Info (circle primary): Cell _____ , Work _____ , Home _____

Address:_____

Primary E-mail Address:
(*for reminders, newsletters, Petdesk access*):_____

Referred By: Location ☐ Website ☐ Google ☐ Yelp ☐
Veterinarian ☐ _____ Friend ☐ _____ Other ☐ _____

Patient Information

Pet Name: _____
Age/Birthdate: _____ Sex: _____
Spayed/Neutered: _____
Breed: _____ Color: _____
Pet Insurance Policy: _____

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Age/Birthdate: _____ Sex: _____
Spayed/Neutered: _____
Breed: _____ Color: _____
Pet Insurance Policy: _____

All professional and medical services must be paid in full at the time they are rendered.

We do not accept personal checks. _____ (initial here)
We accept credit cards, debit cards and cash.
Please visit our website (www.cascadesummitvets.com) for details on all of our hospital policies.

As a pet guardian, you will be held liable for the financial responsibility of services that are performed for each pet. Unpaid balances will be recovered as deemed appropriate by Cascade Summit Animal Hospital (CSAH) management and may incur a $30.00 administration fee. A 1.5% monthly interest fee will be charged on all unpaid balances.

Image Consent: We often use patient pictures for our website, Facebook, and Instagram. Your signature authorizes CSAH to use photographs and videos in print media, brochures, the CSAH website, and on social media outlets. You also agree not to file any claim for revenue, or lawsuit for damages, against this veterinary practice with respect to the release of this information. *Opt out* ☐

Holistic Medicine Consent: "I consent to the use of alternative medical therapies for my pet, including but not limited to: Acupuncture, orthopedic manipulation, herbs, homeopathy, reiki, flower essences, and nutritional supplements." *Opt out* ☐

Customer Pricing Notice:
We have a fee of 3% on credit cards that is not greater than our cost of acceptance. This fee is not applied when using a debit card with a pin.

I understand and abide by the above statements.

Signature:_____ Date:_____

For hospital use: Client ID: _____ / Patient ID(s): _____
Address correct ☐ / Phone numbers entered ☐ / E-mail entered in CS ☐ / Scanned ☐
Referral entered ☐ / Trupanion Trial Offered ☐ Change client classification to email only ☐ Profession ☐