Church Hill Animal Hospital
322 N. 25th Street
Richmond, Virginia 23223
(804) 644-8200

VIRGINIA VETERINARY DISCLOSURE FORM

(Please read carefully before signing)

Church Hill Animal Hospital is a full-service veterinary medical and surgical facility. We are open for business as follows:

> **Monday thru Friday: 7:30 am to 5:00 pm**
> **Saturday: 9:00 am to 1:00 pm**
> **Sundays and major holidays: closed**

Therefore this disclosure form is provided to inform you that we have no in-house, on-duty continuous medical staff care as follows:

1.) Overnight, from closing time at 5:00 pm to opening at 7:30 am.
2.) Weekends, from closing on Saturday at 1:00 pm to opening on Monday at 7:30 am.
3.) Holidays, from closing time before the holiday at 5:00 pm to opening time the day after the holiday at 7:30 am.
4.) Holidays falling on Monday, from closing time Saturday at 1:00 pm to opening time on Tuesday at 7:30 am.

There is, however, someone who will be checking all hospitalized patients during the hours that the hospital is not fully staffed. That schedule is determined by the attending doctor and may vary with the needs of the individual patient. If you have questions concerning this policy, please don't hesitate to ask. Also, if you would like to have continuous overnight care of your pet, discuss those options with the doctor.

I have read this form and I am aware of the above staffing hours.

____ ________________________

Signature of Responsible Party **Date**

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Patient/Client Information

Thank you for choosing **Church Hill Animal Hospital**. We look forward to providing care for your animal companion. Please help us get to know you and your companion by completing the following information.

Date____

(Please circle one) Mr. / Mrs. / Ms. / Dr.

Owner's Name____ Spouse/Other/ Partner _________________________________

Address____ Apt/Unit Number:___________________________

City______________________________________ State_____________ Zip___________________

Home Telephone____ Work Phone____

Cell Phone:____ Spouse/Other's Cell Phone:_____________________________

Spouse's/Other's Work Telephone___________________________ email____

Employer's Name ____

Spouse's/Other's Employer ____

PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED. We will gladly prepare a written estimate if requested. We accept Master Card, Visa, cash and checks with ID. Returned checks will acquire a $35.00 processing fee. In the event this account is turned over for collection, the owner/agent is responsible for fees in the amount of 33 1/3% of the outstanding balance.

Signature of client responsible for pet(s):__________________________Date:_____________

How did you hear about our hospital? (please check all that apply)

Phone book__________ Location__________ Referral__________

Hospital Sign__________ Advertisement__________ Other___________

Individual: someone we may thank?____

Animal Medical History (please complete all information for each animal)

Name____ Species (cat, dog, other)___________________________________

Breed____ Color____

For non-pedigreed cats please check one: Short Hair ________ Medium Hair ________ Long Hair ________

Age (years)______________________________________ Date of Birth____

Sex (please check one): Male_______ Female_______ Neutered Male________ Spayed Female________

Is your pet on any medications? ____________________ If yes, please list ALL medications your pet is currently taking, including heartworm preventative and flea medications:

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