VETERINARY SPECIALTY CENTER
1515 Busch Parkway • Buffalo Grove, IL 60089 • P: 847.459.7535 • F: 847.808.8900 • vetspecialty.com

Client Registration Form

Have you ever been to this hospital before? ☐ Yes ☐ No

Pet Info: Name: _____ Species: ☐ DOG ☐ CAT
Breed: _____ Sex: ☐ Female ☐ Male
Birth Date: _____ ☐ F. Spayed ☐ M. Neutered
Color(s): _____ Weight: _____

Veterinarian:
Please provide the following information so that we may ensure that your hospital records are forwarded to your regular veterinarian:

Hospital/Clinic:_____ Referring Veterinarian:_____
Do you have a secondary veterinarian (such as an emergency hospital) who referred you here today?

Hospital/Clinic:_____ Referring Veterinarian:_____

Primary Owner: Name:_____ Primary Phone:_____
Street Address:_____ Secondary Phone:_____
City/ST/Zip:_____ Email:_____

Co-Owner: Name:_____ Primary Phone:_____
Street Address:_____ Secondary Phone:_____
City/ST/Zip:_____

- I hereby authorize the veterinarians, and all of their affiliates, and their respective employees, agents, contractors and representatives (collectively the "Medical Professionals") to administer treatment as is considered therapeutically and/or diagnostically necessary.
- I authorize medical treatment, as well as possible alternate modes of treatment, as explained to me by the Medical Professionals. I further authorize surgical procedures of an emergency nature, if deemed necessary.
- I further understand that there is a state licensed professional counselor to provide me with coping, grief and other services relating to my pet's health care, status and any decisions which I may make or have made in that regard, and that she will make an appropriate referral for me should she believe that I may benefit from other counseling services. I further understand that (a) I can refuse this service and (b) I will not be billed should I take advantage of these services.
- I give my permission to release case/patient information and/or photos so they may be used in teaching, continuing education, website, veterinary literature, and the like. Except as provided in the preceding sentence, patient confidentiality will be maintained.
- I consent to the release of all of my medical information to Veterinary Specialty Center, Inc., Surgical Referral Service, Ltd., Veterinary Medical Referral Service, Ltd., Midwest Veterinary Dermatology Center, LLC, VSC Emergency & Critical Care, LLC, VSC Sports Medicine and Rehabilitation, LLC, and/or Imaging Center for Animals, LLC (collectively the "Practices").
- I assume full financial responsibility for all charges incurred for the care and treatment of this patient. I further understand that if I fail to timely pay the entire amount due and payable for veterinary services and services ancillary thereto, a monthly service fee of 2% will be added to any unpaid balances. If legal action is instituted to collect the unpaid balance, I agree to pay on demand 33.3% of the unpaid balance as collection fees in addition to all costs for legal expenses, service fees and attorney's fees incurred or paid in collecting these fees in the event of a default.
- Information provided by me is solely for the use of the Practices and for any practice which hereafter begins performing veterinary services at the same premises as conducted by the Practices or in conjunction with the Practices.
- I certify that I am at least 18 years of age and have the authority to make decisions on behalf of the patient.

Owner Signature Date Time Staff Initials

Unsurpassed healthcare for animals in a kind and comforting environment