# Wellborn Road Veterinary Medical Center
# 2851 Rock Prairie Road West
# College Station, Texas 77845
# (979) 693-7806

**ADMISSIONS INFORMATION**

**Date: _____ Reason for visit: _____**

**OWNER INFORMATION- (please print)**

**[Dr./Mr./Mrs./Ms.]**

**Owner's Name: _____**

**Home Phone: _____ Alternate Phone: _____**

**Street: _____ Driver's License# (incl. state): _____**

**City: _____ State: _____ Zip Code: _____**

**Spouse's Name: _____ Phone: _____ [work/cell]**

**Email Address (used to email reminders): _____**

**PATIENT INFORMATION-(please print)**

**(If more than 3 please continue on the back.)**

**Patient's Name Species Breed DOB Sex Neutered/Spayed? Color**

**1._____**

**2._____**

**3._____**

**Previous Veterinarian: _____ Phone: _____**

**How did you hear about us? Google [ ] Yelp [ ] Facebook [ ] Drive By [ ] Referral [ ]**

**STATEMENT OF FINANCIAL POLICY**

**I, the undersigned, also understand that I am financially responsible for all procedures and that payment is due when services are rendered, regardless of outcome of the procedure. I understand that if I refuse to pay for services that I am in violation of Texas Penal Code Sec. 31.04b and Wellborn Road Veterinary Medical Center has a right to prosecute me for Theft of Services. Furthermore, if a patient must be hospitalized, a deposit equaling no less than ½ the estimated cost is required upon admission, with the remainder of the actual cost due upon discharge. Actual costs may vary up to 10% over or under the stated estimate without notice.**

**PLEASE CHECK METHOD OF PAYMENT: Cash [ ] Check [ ] Credit Card [ ] Type: _____**

***(Please note: all returned checks will incur a $35.00 service charge.)**

***(Accounts over 90 days past due will be sent to collections & incur a 40% surcharge.)**

**RELEASE FOR TREATMENT**

**I, the undersigned, do hereby certify that I am the owner (or duly authorized agent of the owner) of the above animal(s). I hereby authorize the Wellborn Road Veterinary Medical Center, their agents, or representatives, to perform the medical or surgical procedures, anesthesia, x-ray examination, drugs, or other such treatments which the doctors deem necessary. I agree to accept full responsibility for the full payment of all services at the time they are rendered. I further agree that if any animal listed above is not picked up within ten (10) days of Certified Written Notification of Discharge, the hospital is released from all liability for placing or disposing of the animal. I hereby state that I have read this release, that I understand the agreement, and that I will adhere to the terms stated herein.**

**Signature X_____ Date_____**