

# Ypsilanti Animal Clinic

## Owner Information

First name \_\_\_\_\_ Last name \_\_\_\_\_

Address \_\_\_\_\_  
Street APT/UNIT City State Zip

Phone Mobile \_\_\_\_\_ Home \_\_\_\_\_ Work \_\_\_\_\_

Email Address \_\_\_\_\_

Referred by \_\_\_\_\_

## Pet Information

Name \_\_\_\_\_ Date of birth \_\_\_\_\_ Age \_\_\_\_\_

Sex \_\_\_\_\_ Spayed/Neutered \_\_\_\_\_ Breed \_\_\_\_\_

Color/Markings \_\_\_\_\_ Microchip Yes No Unsure

Date of last vaccinations \_\_\_\_\_ Location \_\_\_\_\_

## Photographs

I give permission for myself and pet's first name only to be posted online for informational purposes (Facebook posts, Instagram photos, etc.) I understand that all images are property of Ypsilanti Animal Clinic and release any claim to them.

Owner's Signature \_\_\_\_\_

## Financial Agreement

**Please understand that full payment is due at the time of service, and all sales are final & no returns or refunds will be given. Thank you!**

**Accepted forms of payment:**

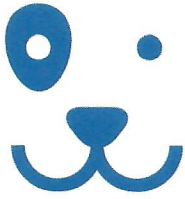
**Cash, Visa, Mastercard, Discover, American Express, Care Credit. No checks**

Service charge: If I do not pay the full balance amount within 25 days of the visit date, a service fee of \$10 will be added to my account every 30 days until the balance is paid in full. In the case of default of payment, I promise to pay any legal interest on the balance due. I agree to reimburse Ypsilanti Animal Clinic for the fees of any collection agency, which may be based on a percentage at a maximum of 33% of the debt, and all costs and expenses, including a reasonable attorneys' fees, we incur in such collection efforts.

**I have read, understood, and agree to the financial terms and the no return or refund policy.**

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

734-485-1622 Phone  
734-485-6312 Fax  
staff@ypsivet.com Email  
37 Ecorse Rd  
Ypsilanti, MI 48198



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## New client deposit policy

**A \$25.00 non-refundable deposit** is required to reserve an appointment for a new client upon scheduling. The deposit will be credited toward the visit on the day of your appointment. Balance is due the day of appointment in full via credit card or cash, no personal checks. By leaving the \$25 non-refundable new client deposit I agree to the terms.

## No Show Policy:

Any new client that does not show for a scheduled appointment will **forfeit** their deposit and will be **required to leave a new deposit** for any future appointments. **No exceptions!**

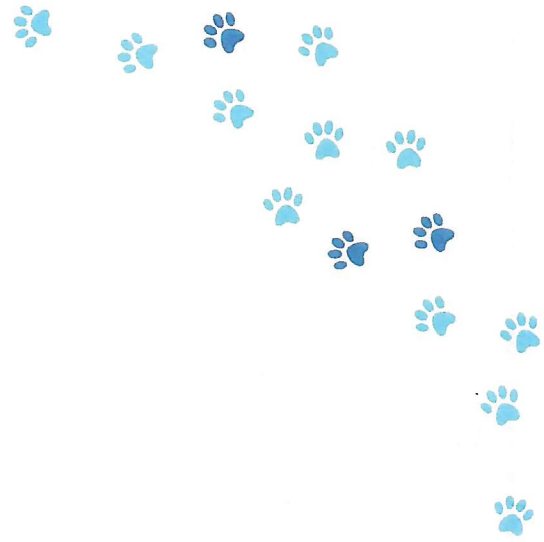
**I have read, understood, and agree to the non-refundable deposit policy**

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

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## No Show, Missed Appointment Office Policy Form

When our office books your appointment, we are setting aside a dedicated time slot just for you. We only ask that if you must reschedule your appointment, that you please provide us with at least 24 hours' notice. This courtesy makes it possible to give your reserved time slot to another patient who would be more than happy to accept.

There will be no charge for one missed appointment, however, if a second missed appointment or late notice of cancellation, there will be a required non-refundable deposit of \$25 to schedule or reschedule future appointments which will be applied to your future visit.

Every patient in our practice receives this unique reservation. When your appointment is made, a time is reserved, your materials are ordered, and we make special arrangements to be ready for your visit. Except for emergency treatment for another patient, you can expect us to be prompt. We, of course, would appreciate the same courtesy from you. Thank you!

**I have read, understood, and agree to the non-refundable deposit policy**

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

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