LEESBURG VETERINARY INTERNAL MEDICINE

PATIENT REGISTRATION FORM

165 Fort Evans Rd. NE
Leesburg, VA 20176
P: 703.777.5866 | F: 703.562.7049
www.InternalMedicineVets.com

CLIENT INFORMATION

TODAY'S DATE:

LAST NAME:	FIRST NAME:		
CELL PHONE:	HOME PHONE:		
WORK PHONE:	EMAIL:		
STREET ADDRESS:	CITY:	STATE:	ZIP:
FINANCIAL RESPONSIBLE PARTY - EMPLOYER NAME:			
ALT. AUTHORIZED CONTACT LAST NAME:	FIRST NAME:		
CELL PHONE:	HOME PHONE:		
WORK PHONE:	EMAIL:		
VETERINARIAN NAME:			
VETERINARIAN AFFILIATED HOSPITAL:			

DO YOU CONSENT TO AND WISH TO HAVE US CONTACT YOUR DOCTOR TO OBTAIN COPIES OF MEDICAL RECORDS? ○ Y ○ N

HOW DID YOU BECOME AWARE OF OUR PRACTICE? ○ REFERRED BY DOCTOR ○ PREVIOUS CLIENT ○ PERSONAL RECOMMENDATION BY: ○ FOUND ON THE INTERNET USING:

HAS THE PATIENT BEEN SEEN BY ANY OTHER PARTNER PRACTICE AT THE LIFECENTRE? [IF YES, PLEASE MARK ALL THAT APPLY]

○ AD&OS (DENTISTRY) ○ AECC (EMERGENCY/CRITICAL CARE) ○ BVNS (NEUROLOGY) ○ CVCA (CARDIOLOGY)
○ TOS (ONCOLOGY) ○ ECFA (OPHTHALMOLOGY) ○ VSC (SURGERY) ○ DERMATOLOGY

PATIENT INFORMATION

NAME:	DATE OF BIRTH:	○ FEMALE ○ MALE	
SPAYED/NEUTERED: ○ Y ○ N	COLOR:	○ DOG ○ CAT	BREED:
LIST PRIMARY CONCERNS:			
INDIVIDUAL COMPLETING REGISTRATION FORM:			

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AUTHORIZATION TO TREAT and FINANCIAL RESPONSIBILITY

I authorize Leesburg Veterinary Internal Medicine, its Veterinarians and designated support personnel to examine and provide treatment for the pet presented. I assume financial responsibility for all charges incurred to this patient. If I am not the owner of the animal I represent, I have been given authority by the owner to obtain medical and/or surgical treatment for this patient, and to incur charges for its care. I understand payment, in full, is due at the time service is provided. I understand LVIM does not bill. Third-party financing is available and information can be provided to me upon request. Any outstanding balance will incur a late charge of 1.5% per month. LVIM will also recover reasonable collection costs, attorney's fees and court costs incurred as a result of my failure to pay in accordance with this agreement. Any financial concerns should be discussed with the doctor prior to treatment in order to comprise a treatment plan in the best interest of the pet and pet's family. Medical information and contact information may need to be shared with TLC services and other veterinary hospitals in an effort to have a collaborative treatment plan. I consent to the release of information pertaining to this patient. I have read and fully understand this authorization for treatment and financial responsibility statement.

Signature of Owner/Responsible Agent: _____ Date: _____

Name of Owner/Responsible Agent:_____