Friends of Sierra - New Client Form

Date: _____

Client First Name: _____ Client Last Name: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Preferred Phone that we may contact you on: _____

E-mail address: _____

Pet's Name: _____ Species: Canine / Feline Breed: _____ Age: _____

Sex: Male / Female Spayed / Neutered? Y / N Color/Markings: _____

Who is your daytime veterinarian/office? _____

Is your pet currently on any medications? (Please list name, dose, frequency, and how long they have been on the medication):

_____

_____

_____

What kind of food do you feed your pet? _____

Is your pet currently taking any supplements? _____

_____

Why are you bringing your pet into today? _____

_____

Does your dog have any behavioral concerns we should be aware of? Please explain:

_____

_____

Has dog been trained in bite work? ☐ Yes ☐ No

Does your dog have a bite history? ☐ Yes ☐ No

If you answered 'yes' to either of these questions your dog will need to be muzzled for treatment.

Authorization To Provide Care/Treatment:

I am the owner or authorized agent of the owner of the pet listed above, hereby and direct the veterinarians/physical therapists of Friends of Sierra (FOS) or their assistants to perform all rehabilitation assessment and treatments within accepted physical therapy guidelines as deemed advisable and/or necessary for my pet. I authorize FOS to obtain all medical records regarding my pet as is necessary for the thorough and complete evaluation and treatment of my pet. I understand that portions of my visit may be recorded for educational purposes. I understand that there is no guarantee nor can one be made as to the results or cure of any therapy. I understand that the veterinarians/physical therapists of FOS recommend therapy and treatment options but that other persons may have different opinions about what therapies and treatments are necessary or appropriate. I agree to pay, in full, for services rendered. I understand that payment is due at the time services are rendered. If for any reason payment is not made at the time services are rendered or within 10 days thereafter, I understand that my account may be referred to a collection agency. In the event that my account is referred to a collection agency, I agree that FOS may add an amount to my outstanding account balance to reimburse FOS for the reasonable collection charges (but not including attorney's fees) imposed by the collection agency. I agree to hold harmless FOS their owners, employees, and agents from any and all liability of any nature, loss or injury to self, loss or injury to family including pet, loss or injury to guest as a result of participating in any FOS assessments, treatments, classes and programs. I personally assume all liability for the care of my pet while under the care of FOS.

Signature: _____ Date: _____