For office Use Only:

____
Account Number

ANIMAL MEDICAL CLINIC
701 Lion Parkway
Columbia, TN 38401
(931) 388-6215

Home Phone#:___________

Cell #: _______________

OWNER'S NAME / ADDRESS:

____
First Middle **Last**

____
Street/P.O. Box City State Zip Code

SSN: _________________________ ***OR*** **D.L.#:** __________________________

EMAIL Address: _______________________________

Employer's Name/ Phone Number:

____
Business Name Business Phone

SPOUSE/ FAMILY MEMBER NAME: **Spouse's Cell Phone:**______________

____
First Middle Last

Employer's Name/ Phone Number:

____
Business Name Business Phone

PAYMENT REQUIRED AT TIME OF SERVICE

Full payment is required at the time of service. We accept most major credit cards, cash or check. I agree to pay any and all unpaid balances, including but not limited to the principal balance of my bill, and if I am turned over to a collection agency or attorney for collections, I agree to pay those costs of collection, attorney fees, and court costs.

RETURN CHECK FEE: $20.00 per check.

Payment Method (Please Circle): Cash Check Credit Card Care Credit

Signature: ____ Date: _______________