VETERINARY HEALING ARTS℠

Name _____ Spouse/Partner: _____
Address: _____
City/State: _____ Zip Code: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
*82 / Caller ID Block (Please circle if applicable) ☐ May we call you at work?

Email: _____ Drivers License: _____
Employer: _____ Occupation: _____

Referred by:
☐ Primary Veterinarian: Name_____ Clinic Name:_____
☐ Secondary Veterinary: Name_____ Clinic Name: _____
☐ Friend ☐ Family ☐ Yellow Pages ☐ Internet ☐ Groomer_____
☐ Other _____

It is very important to us that your pet's primary veterinarian know what treatment and medications your pet is receiving from us. Please provide the contact information of the veterinarian that you would like to receive these progress reports.

Veterinarian Name: _____ Clinic Name: _____
Veterinarian Address: _____
Veterinarian Phone Number: _____

Pet Name: _____ Sex: ☐ Male ☐ Female ☐ Spayed/Neutered ☐ Intact
Species: ☐ Canine ☐ Feline ☐Other _____ ☐ Breed: _____
Color: _____ Birth date: _____ Weight: _____
Originally obtained from: _____

Veterinary Healing Arts, Inc. (VHA) specializes in the treatment of allergies, ears, skin disease and behavioral disorders only. If your pet has any other medical or surgical needs, you should consult with your primary care veterinarian.

All fees are due upon release of your pet. Any medications, antigens, or other medical supplies mailed to you will be billed separately and in addition to appointment charges. We accept cash, personal checks, MasterCard, Visa and Discover. Should any checks be returned for nonpayment there will be a $25 returned check fee.

We are leaders and teachers in the fields of veterinary dermatology and behavior. Medical files, thus case information, and/or photos may be used in teaching, forms, continuing education, website, veterinary literature and the like. I authorize the release of case/patient information for such purposes; client confidentiality (names and personal information) will be maintained.

I understand that no guarantees can be made as the results obtained from medical or behavioral treatment. Further, I assume financial responsibility for all charges incurred by the patient.

_____ _____

Signature of Owner or Responsible Agent **Date**